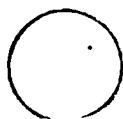


CHANGE AND CONFLICT IN HEALTH VISITING PRACTICE:

the assessment of professional competence in the  
dilemmas in assessing the professional competence of  
education of student health visitors

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## Abstract

Recent events in professional practice have highlighted the growing concern amongst professionals as to the extent to which the interpretation of professional knowledge reflects the changing characteristics of practice situations. Authors have attributed this crisis in confidence to the development of an epistemology of practice grounded in a model of technical rationality. This traditional model based on a process of instrumental problem solving, using scientific theory and techniques, has accentuated the gap between the theory of practice and the reality of the practice setting.

A similar phenomenon is apparent in health visiting practice and raises a fundamental question in professional education: what is understood by competent practice. Although defining competence in practice has been the focus of much research, some critics now argue that the most important areas of professional practice lie beyond the conventional boundaries of professional competence. Indeed the understanding and appreciation of the concept of professional artistry is fundamental to the process of defining competence in practice. It is my belief that this concept plays a major role in the level of competence displayed by practitioners.

The empirical work therefore was designed to examine a fundamental issue in professional education: the relationship between the interpretation of professional practice and the process of assessing competence in practice. The multistage mixed research design used to analyse and explore the different interpretations of professional knowledge and adopted paradigms of practice not only demonstrates the current emphasis on an epistemology of practice grounded in a model

of technical rationality but also the lack of a theoretical framework for the process of assessing competence in practice. Indeed the findings demonstrate the need to develop a conceptual framework for practice which not only acknowledges the essential role of the concept of professional artistry in the interpretation of professional practice but also facilitates the development of an epistemology of practice grounded in reflection-in-action. It is these findings which highlight the critical role of the Fieldwork Teacher in facilitating these processes.



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I am indebted to my family for their support and tolerance throughout, in particular my husband Jim and my sister Bridget. Finally my sincere thanks go to Mary Flight for her patience and tolerance in typing the numerous drafts of this thesis.

### NOTE:

The identity of individuals has been obscured by the changing of names. The female gender has been used throughout the thesis for convenience of presentation.

Sheila Twinn

July 1989

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## CHAPTER 1

### Conflicting paradigms of health visiting: a dilemma for professional education and practice

#### Conflicting paradigms of practice: a historical perspective

The recent inquiries into child deaths (Brent: L.B. 1986, Greenwich: L.B. 1987) illustrate the growing crisis in confidence in health visiting intervention in particular practice settings. Robinson (1985 : 69) argues that Jeffreys identified this phenomenon a decade ago describing a 'prevailing mood of pessimism and self doubt within the maternal and child health services'. This was partly attributed to the tendency of professionals to define the health needs and problems of clients using their own criteria rather than those of the clients. Research into the clients' perception of health visiting practice demonstrates similar findings (Foxman 1982 , Field 1982 , & Clark, 1984a), identifying a significant minority of clients dissatisfied with the service provided. Perhaps justifiably the discussion resulting from these findings was centred on the skills of the practitioner rather than questioning the appropriateness of the practice to the client's situation. However, Robinson (1985) argues that the profession has tended not to question the validity or the conceptual origins of health visiting strategies, nor indeed the nature of health visiting knowledge. Furthermore, she considers the individualistic approach adopted by the majority of practitioners irrelevant in many practice situations. It is these issues which have contributed to the crisis in confidence in health visiting and have stimulated the recent debates amongst practitioners about the nature of professional knowledge and the development of conflicting paradigms in practice.

However, in order to explore these issues in the context of contemporary practice the development of the health visiting profession needs to be reviewed.

The foundation of health visiting has traditionally been identified as the formation of the Ladies Sanitary Reform Association in Manchester and Salford in 1862. The Association has been described as 'establishing a model of low cost preventive health care based upon house to house visiting' (While 1987 : 129) Robinson (1982a : 5) argues that the work of teaching hygiene and child welfare, giving social support and the teaching of mental and moral health undertaken by the 'respectable working women' appointed by the Association, is considered the 'direct antecedent' of health visiting practice. The actual employment of health visitors or lady health missionaries by local authorities began towards the end of the nineteenth century. However, although the origins of health visiting were grounded in the voluntary movement, the influence of epidemiological studies and the particular interests of local Medical Officers of Health, in addition to central government are evident in the development of health visiting practice, and thus contribute to the current conflicting paradigms of practice.

Evidence generated from the epidemiological studies of the cholera epidemic in the mid nineteenth century initiated general interest in the standard of public health. This was reinforced by evidence demonstrating the variation in life expectancy rates for different social classes and in particular the high infant mortality rate (IMR) (1) which peaked at 163 deaths per 1,000 live births in 1899 (McCleary 1933). The Report of the Inter-departmental Committee on physical deterioration published in 1904 led to the organisation of

a national conference on infant mortality in 1906. Although demonstrating the confusion over the cause of infant death, the need to provide maternal education and encourage maternal responsibility was clearly identified (Twinn 1982). Health Visiting was identified as the agency to fulfil this role, thus establishing practice firmly in the field of maternal and child health. Robinson (1987) argues that little work was actually carried out in maternal health, the emphasis being clearly placed on the infant and child. However, she goes on to argue that health visiting practice varied considerably in different parts of the country. In County Durham only a quarter of the time was spent on maternal and child health, the majority being spent with individuals with Tuberculosis and other infectious diseases such as measles and influenza, once more demonstrating the influence of epidemiological studies.

The emphasis in practice in the early twentieth century was influenced by the interest and commitment of local Medical Officers of Health and this phenomenon was demonstrated throughout the country. A scheme to reduce the IMR implemented by the Medical Officer of Health for the Borough of St Pancreas included home visiting by the health visitor following the notification of birth and establishing a School of Mothercraft known as the 'Welcome' (Sykes 1910). However, Wakeman-Reynolds (1987) argues that the influence extended by Medical Officers of Health over health visiting practice was still apparent in 1949, when they made a commitment to only employ those health visitors who were trained nurses.

Central government finally responded to local initiatives in improving the standard of public health, by introducing specific

legislation concerning maternal and child health. This included the notification of Birth Act in 1915 and the Maternity and Child Welfare Act in 1918, thereby reinforcing the focus of health visiting practice on mothers and young children. Although the emphasis in practice remained within the area of maternal and child health the different interpretation of the work of the health visitor at this time was demonstrated by the evidence given to the Inter departmental Committee on Physical Deterioration and the reports from the Manchester and Salford Public Health Society. While (1987 : 131) cites evidence which describes health visiting as reporting sanitary defects in the house, finding work for men and women, sending children to the seaside, teaching families to lead moral and healthy lives and making the beds of sick patients. These early differences in practice were reinforced by the lack of any established central guidance in the provision of health visitor training.

The first training course for health visitors was set up in 1892 by Florence Nightingale. She described the training needs of health visitors as 'different and more varied but not lesser than nurses' (Staunton 1980: 481). However, it was not until 1919 that the Ministry of Health and the Board for Education jointly implemented a two-year training scheme for health visitors. This was to include subjects in social and domestic science and to run in association with a university establishment. It was recommended that these courses should be recognised as the official training for health visiting. However, trained nurses and graduates needed only to complete a further years training. It was not until 1925 that a midwifery qualification was a prerequisite for health visitor

training but also in this year the course was reduced to six months. Although the two-year training continued at three colleges it was possible to undertake the revised six month course with either an educational institute or local authority or voluntary organisation. Davies (1980: 1705) argues that this approach to training generated an 'extreme discrepancy' in the philosophy of training which led to different interpretations in health visiting practice. Despite the Royal Sanitary Institute becoming the recognised examination body for health visiting and the introduction of a statutory qualification for practising health visitors in 1929, the three methods of training remained until the 1950s. Although by 1950 some training schools had managed to introduce the new syllabus proposed by National Standing conference (2) which gave a much greater emphasis to social sciences and theory generally, they were not able to alter the examination which remained grounded in the medical model of health visiting supported by the Medical Officers of Health (White 1987). The discrepancy between this medical model of assessment and the need to address the changing health needs of society following the introduction of the welfare state added to the debate of the changing role of the health visitor and thereby the development of conflicting paradigms of practice. In 1954 the Ministry of Health finally responded to this debate by setting up a working party to enquire into health visiting practice. This was chaired by Sir Wilson Jameson , a retired civil servant who had also been an M.O.H. White (1987) argues that it was significant that a health visitor was not included within the working party, despite the fact that an experienced social worker had been appointed to chair a similar inquiry in social work.



The Jameson Report (M.o.H 1956) which was published in 1956 commented on both practice and training. The report criticised the profession for the diverse demands made of health visitors. It proposed that health visitors should become general family visitors with the primary functions of health education and social advice. It recommended that their work in clinical fields such as diabetes, old people and tuberculosis should end and Jameson described health visitors rather unflatteringly as 'willing horses'. This may have influenced the proposals which were very general and failed to anticipate new health needs or indeed a new type of worker (White 1987). The report criticised health visitor training because 'it was too short, too crammed, too theoretical' (M.o.H. 1956 para 352). The result of the enquiry was the Health Visitor and Social Work (training) Act 1962. This established the Council for the Training of Health Visitors. In 1971 the importance of education as well as training was acknowledged by amending the title of the Council to the Council for the Training and Education of Health Visitors (CETHV). The present curriculum was introduced in 1966. This lengthened the course to 51 weeks by implementing a period of supervised practice to provide a link between theory and practice. This increased the practical aspect of the training considerably and introduced the assessment of fieldwork practice in the final examination. Wilkie (1979 : 29) describes the concern expressed by the Council at the lack of a formal method of monitoring the standard of the practitioners involved in this aspect of the students' training and it is significant that this has remained a concern of those involved in health visiting education (3). The theoretical input was expanded to include sociology, psychology and social policy in the syllabus, acknowledging the relevance of

these disciplines to health visiting practice. The courses were now all provided in colleges of further and higher education, but required approval by the CTHV. However, the introduction of a new curriculum provided a further dimension to the conflicting paradigms of practice: the differing expectations and interpretations of practitioners qualifying pre and post 1966. At the present time the training and education remains unchanged although concern over the length of the course continues as it is still considered too short to consider many of the issues in sufficient depth (National Standing Conference 1980).

#### Contemporary paradigms of practice: the current debate

Contemporary health visiting practice has therefore developed from a historical background which White (1987 : 164) describes as 'rooted in environmental problems, infectious diseases, hygiene and mother and child welfare'. Indeed the National Health Act of 1946 which required local authorities to provide a health visiting service defined health visitors as women 'employed by a local authority for the visiting of persons in their homes for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant and nursing mothers and as to the measures necessary to prevent the spread of infection' (Wilkie 1979 : 115). This traditional role is partly maintained by health visiting today. Wiseman (1982) demonstrated that 215 health visitors in the North West Regional Health Authority continued to identify priority care groups as the under fives, including those with special needs as defined by the Warnock Report (1978), antenatal and post natal mothers, the single parent and 'problem' families. However this traditional role still allows for variation in practice. Clark (1981) describes 37 studies of the work of health visitors, which

despite conforming to this traditional role, demonstrate a variation in identified health visiting tasks. The evidence from the Health Visitors Association (HVA) to the Community Nursing Review supports this finding. In a five day period in one Health Authority over 300 different actions were identified which were undertaken by the health visitor in association with the traditional role of maternal and child health.

The conflicting paradigms of practice presented within one health authority is another dimension in the debate of the interpretation of professional practice. Until recently managers have attempted to control this situation by introducing a system of structured home visiting. This is defined as a method of advising or directing health visitors in planning and carrying out home visits and may take the form of a programme of visits, a target number of visits or a check list of information to be obtained or screening procedures to be undertaken (HVA 1985). Although some criticism occurred at the introduction of these schemes, Connolly (1982) clearly demonstrated the lack of consistency in practice when practitioners were asked to identify the factors which were used to assess a child's developmental progress. Therefore, although these schemes were introduced as a method of monitoring practice and the standard of care offered to clients, recent events have highlighted the initial concern expressed in adopting this approach to practice (Goodwin 1988). Indeed it is also significant that this paradigm of practice has not resolved the practice dilemma associated with child protection. Although Robinson (1982a) describes the health visitor's direct responsibility for child life protection being revised in 1933, Dingwall (1982) argues that family policing has always been a function of the health visitor. Anecdotal evidence

from clients substantiates this opinion. However the continued publication of enquiries into child abuse demonstrates the lack of expertise of practitioners in this practice situation and contributes to the crisis in confidence in health visiting.

The school health service has until recently been included in the traditional paradigm of health visiting. The implementation and expansion of the school nursing service has partly altered this pattern, particularly where career structures have developed for nurses working specifically in school health. However health visitors continue to receive joint appointments as both health visitor and school nurse thereby reinforcing this traditional paradigm. Although a major role in school nursing is to participate in child health surveillance programmes incorporating medical inspections and health interviews, another important aspect in school health programmes is the involvement with health education programmes on either a group basis or in a one to one situation. The effectiveness of this practice in schools may be questioned unless the health visitor has undertaken further training in groupwork skills or teaching and indeed it may be more appropriate for the health visitor to work as a resource person to the teaching staff. However this evidence demonstrates that even within this traditional paradigm different interpretations of practice can be identified.

Health visiting with the elderly continues as an issue for debate within the profession. Fitton (1984) describes 90% of a sample of 111 community nurse managers positively stating that the elderly should be included within the remit of the generic health visitor. Continuing demographic changes and the general trend of improvements

in the infant mortality rates provide evidence to support this comment. It is perhaps pertinent to note that in 1956 the infant mortality rate was 24.4 per 1,000 live births and this had fallen to 9.4 in 1985 (Central Statistics Office 1987). Many health visitors, particularly those working in an attachment scheme with a General Practitioner (GP), have a small number of elderly clients. These have usually been acquired from the age-sex register or by referral from the GP. However, many health visitors are not actively working with the elderly. Wiseman (1982) demonstrated in her study of 215 health visitors that the described priority care groups only made up 6% of the community care group population. It was only a minority in the study that cited the elderly as a priority group, despite the over sixty fives constituting 15% of the population in the 1980s (C.S.O. 1988). This is one area where specialism in health visiting has been developed with staff being appointed to work specifically with elderly clients. This is often in direct response to expressed needs from either a hospital discharge or a referral from a GP., voluntary group or the carer. There are relatively few examples of health surveillance programmes being offered for the elderly in comparison to those described for children. The professional organisation for health visitors (the Health Visitors' Association) has identified the elderly as a priority client group (HVA 1985 : 32) and recommends that this client group should receive a similar priority to the under fives, thereby highlighting the need to reconsider the interpretation of professional practice.

However, although the emphasis on the interpretation of practice remains grounded in a more traditional paradigm, evidence suggests that practitioners are beginning to reconsider their interpretation of practice. McFarlane (1982) suggested that an epidemiological

approach to practice should be introduced. It is pertinent to note that this approach as well as providing a significant influence in the development of health visiting also reflects the principles of health visiting practice (CETHV 1977) which are discussed in depth later in this chapter. In adopting this approach practitioners must establish the health needs and the health profile of their community and use the findings to determine and target priorities in practice. Although individual practitioners have attempted to implement this approach for sometime (Allen & Mitchell 1983, Elphick 1984) more recent initiatives demonstrate a commitment amongst practitioners to develop a paradigm of practice grounded in the principles of health visiting practice rather than client groups (Health Visitor Development Group 1988).

Another important development in practice is the involvement of health visitors in Community Health Initiatives. Drennan (1985) describes some of the projects where health visitors have been involved, both successfully and unsuccessfully. She suggests that the failures may relate to 'the health visitors displaying hostility to any questioning or intrusion of their professional role or territory, or the health visitor being ill equipped to deal with a questioning confident group of people' (Drennan 1985 : 17). Where health visitors have been successful they have shared their knowledge and expertise openly and worked in partnership with the community members making decisions jointly. Hennessey (1985) describes this approach to health visiting practice as emancipatory care and considers it fundamental to determining effective strategies in practice. Networking with community groups is playing an increasingly important role in practice and may prove to be a much more effective method of working than the traditional

individualistic approach currently employed by many practitioners.

The Child Development Project is another example of the changing interpretation of professional practice. The programme which is described as 'essentially a comprehensive parent support programme, with its ultimate goals the achievement of increased development of young children, especially those facing economic and social disadvantage' (Early Childhood Development Unit 1984 : 47), is based on a philosophy of practitioners working in partnership with clients. It is this concept which distinguishes this paradigm of practice from that of the traditional one of maternal and child health where practitioners generally work with clients in a directive manner, thereby inhibiting clients from participating in the decision making process. Indeed the programme aims directly at helping parents make their own health choices and raising their self-esteem. Although both the above paradigms of practice are important illustrations of the changing interpretation of health visiting practice in order to meet different health needs, Drennan (1985 : 70) doubts whether the education and training currently offered to health visitor students equips them to meet these interpretations of practice.

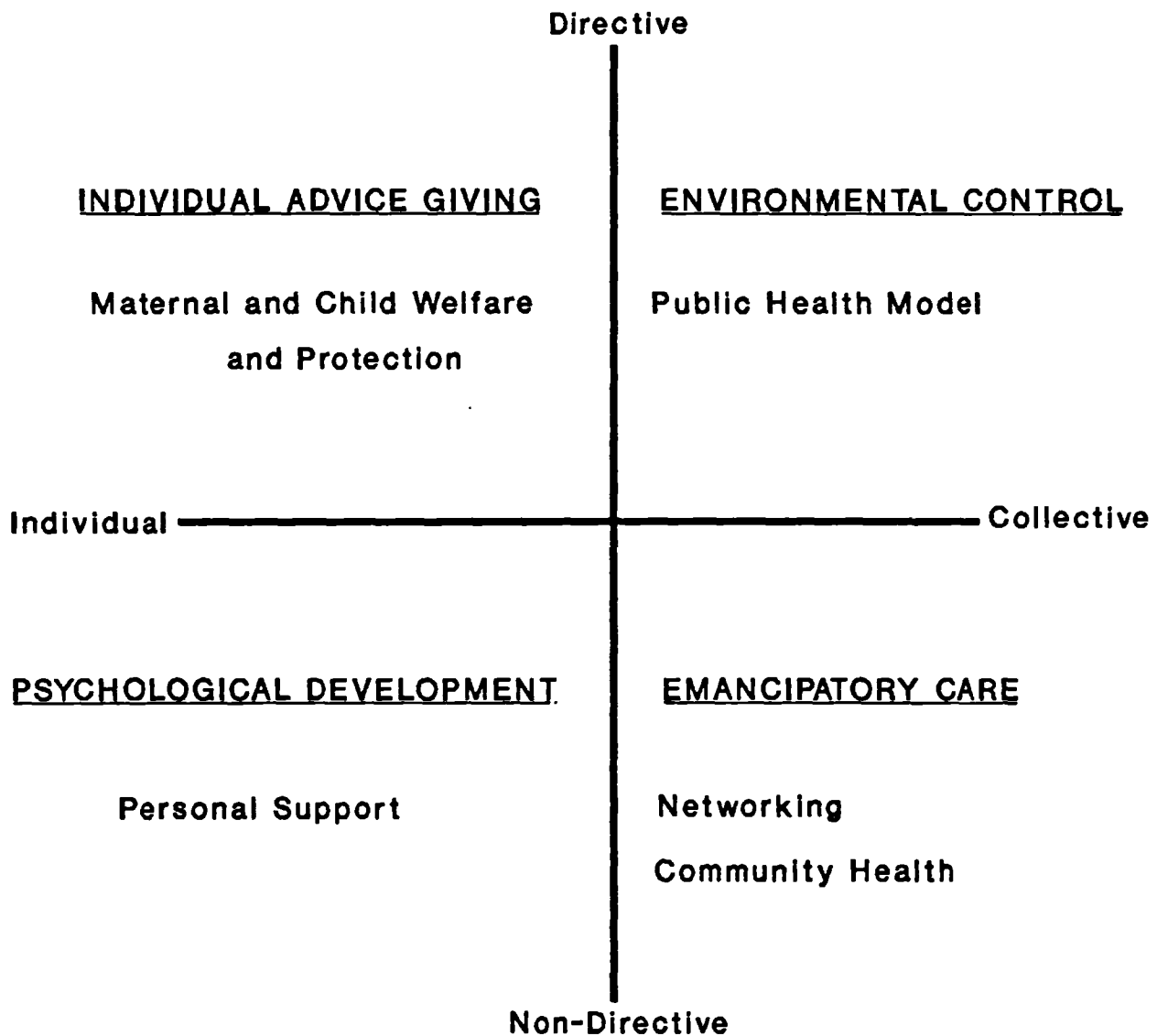
This review of contemporary health visiting practice not only highlights the contrasting interpretations of professional practice but also the different and sometimes conflicting paradigms of practice within that interpretation. This phenomenon is demonstrated in the traditional paradigm of maternal and child health where some practitioners have changed the focus of practice from the child to the parent and have introduced a client centred approach (as illustrated in the Child Development Project).

Although this phenomenon may have stimulated and contributed to the current professional debate I believe that the present interpretation of practice can be divided into four distinct domains and these are demonstrated, using a framework adapted from that developed by Beattie (1988) in figure 1. 1.



# Roles and Paradigms in Health Visiting

Figure 1.1



*(Adapted from Beattie 1989)*

Indeed I would argue that currently the majority of practitioners have adopted a paradigm of practice clearly located within the individual directive domain which implicitly raises the issue of their perception of the nature of professional knowledge. However, the current developments in nursing, such as Project 2000 (UKCC 1986) which introduces the concept of the Specialist Practitioner in Health Promotion and the need to respond to changing health needs, and the Community Nursing Review (DHSS 1986) which recommends establishing Neighbourhood Nursing Teams, nurse practitioners and consumer participation in health care, identify the demand for a radical change in the interpretation of professional practice. This belief is supported by Robinson (1985) who argues that the individualistic approach adopted by many practitioners is often inappropriate to practice situations and in particular to the rapidly changing health needs of Society. Indeed health visitors can no longer indiscriminately adopt a specific paradigm of practice to meet the variety of tasks which have been suggested by agencies and government reports but must reflect on their practice using both the principles of health visiting and an understanding of professional knowledge to determine strategies in practice. However, the nature of health visiting knowledge (and therefore implicitly the interpretation of practice) is influenced by the process of professionalisation and this issue requires addressing before exploring the nature of health visiting knowledge and the implications for assessing competence in practice.

## The process of professionalisation and the influence on the interpretation of professional practice

The term professionalisation is usually defined as the process by which an occupation develops to meet those criteria attributed to a profession (Hoyle 1985). However, it is not the purpose of this discussion to debate the professional status of health visiting, which using previous evidence has been classified within the category of the minor professions (Glaser 1974), but to consider those factors within the process of professionalisation which may influence the nature of health visiting knowledge and thereby the interpretation of professional practice.

The origins of health visiting have been grounded in the respectable working woman seeking to influence health related behaviour by giving advice and providing education for women with infants and children. Robinson (1982a) argues that health visiting achieved initial legitimacy through its association with the infant welfare movement and the local authority public health movement, in particular from the subordinate but validating relationship with the Medical Officer of Health. Following the reorganisation of the National Health Service (NHS) in 1974 health visiting found itself in a new setting which challenged its authority in several ways. Health visiting had been absorbed into the organisational hierarchy of nursing in which it was deemed powerless, not only from the size of professional groups within the structure but also in financial terms since the majority of the budget was allocated to curative rather than preventive care (DHSS 1986). The lack of power within the hierarchy has remained an issue in the development of health visiting (Orr 1988). This reorganisation also brought health

visiting into an environment where the power base had always been with the medical profession and traditionally health visiting had experienced a poor relationship with medical consultants and (despite G.P. attachment schemes (3)) General Practitioners. This in part was attributed to the close professional relationships between health visiting and the Medical Officers of Health. The move into the hospital sector also generated criticism from practitioners and the sparse use of nursing skills as low status professionally. Coinciding with the reorganisation, health visitors in addition experienced the loss of some of the traditional roles in child care to Social Services. These factors in association with conceptual debates challenging the idea of professional expertise in changing or influencing health behaviour contributed to the crises in confidence experienced by health visitors at this time (Robinson 1985) and seriously questioned the nature of health visiting knowledge and thereby the interpretation of professional practice.

The restructuring of the NHS in 1982, and more specifically the implementation of the recommendations of the NHS Management Inquiry in 1984 (DHSS 1984) highlighted the issue of accountability in practice. Although a criterion in the process of professionalisation, the issue of accountability has serious implications for practice and therefore the nature of professional knowledge. In health visiting the clients generally do not initiate their involvement with the practitioner nor indeed is it always apparent as to whom is the client or where professional responsibility lies. This has particular implications in instances of suspected child abuse where the health visitor has a professional responsibility in supporting the parents as well as maintaining professional accountability in the arena of child protection.

The question of accountability is also raised when defining the caseload for which the health visitor has responsibility. The caseload is defined as the members of the population living within a particular geographical location or registered with a particular General Practitioner (ENB 1986). In many instances health visitors are working with client ratios which far exceed those recommended by the DHSS (HVA 1987). This has implications for practice and therefore the nature of professional knowledge particularly when considered in relation to the Code of Professional Conduct (UKCC 1984). This document clearly states that the individual practitioner is accountable for his/her own practice. However it is pertinent to the discussion to acknowledge that prior to the establishment of the United Kingdom Central Council (UKCC) (4), a health visitor's professional practice could only be questioned in her capacity as a Registered Nurse. It is interesting however that of the four health visitors who were required to attend the English National Board Investigating Committee during the period of July 1983 to March 1985, only two cases were for professional misconduct. In one case this involved a breach of confidentiality and the other involved an unsatisfactory standard of performance relating to record keeping and child health surveillance (Lee 1985).

One other important professional issue to emerge from the restructuring of the NHS in 1984 was the disbandment of the Community Nursing Sectors within some District Health Authorities thereby changing the management structure of many health visitors. Within the new organisation it was possible for a manager with direct responsibility for community nurses to have no appropriate professional experience. This has been identified as an area of

professional concern as practitioners need access to an expert source of professional advice and support in the case of actual and suspected child abuse as well as in identifying the need for professional development (HVA 1987). However, White (1987) argues that a Griffiths style of management provides health visitor managers with the opportunity of gaining professional authority by improving their knowledge base. She argues that health visitors and managers meeting together should agree a philosophy and policy for a particular area of practice. This would provide a framework for the development of practice and a method of evaluating practice outcomes thus facilitating the development of professional knowledge, which in turn has implications for the interpretation of practice.

The need to reconsider and revise the recommendations made by the Jameson Committee in 1956, in response to the changing health needs of society had been argued by practitioners for a considerable length of time (NSC 1980, HVA 1985). In 1985 the DHSS appointed a team for six months to review the Community Nursing Services. Although the terms of reference included all disciplines in community nursing it is interesting to note once again that a nurse with community experience was not directly appointed. The team described the fundamental weakness of community nursing as one 'trapped by tradition' (DHSS 1986). They observed health visitors working in traditional ways with traditional client groups which they argued would make teamwork and flexibility of approach difficult if not sometimes impossible. Although some of these findings conflict with those of professional groups and individual practitioners who acknowledge and demonstrate innovative practice, the evidence of the Community Nursing Review clearly demonstrates the different interpretations of professional practice amongst

practitioners.

Glaser (1974) argues that this phenomenon demonstrates an inherent problem for the minor professions. He describes the professional practice of these occupational groups as one of shifting ambiguous ends without clearly defined contexts of practice thus making it impossible to develop a base of systematic professional knowledge. This pattern in professional practice is demonstrated in health visiting and has been influenced by the process of professionalisation. The nature of health visiting knowledge was initially influenced by the association with the infant welfare and public health movement. The crisis in confidence experienced in the profession in the mid 70s coincided with a loss in status resulting from the removal from the statute of traditional health visiting practice associated with child care, and with the challenge of a new professional setting. Within this setting came the additional demands for accountability in practice and value for money and open questioning of health visiting practice in a series of public enquiries into child deaths. Alongside these changes the professional management structure was revised which frequently left practitioners with little support from those with the professional expertise who could help to address these issues of professional knowledge. Indeed, the government's review of the profession identified new directions in the process of professionalisation and once more questioned the nature of health visiting knowledge. These influences during the process of professionalisation have contributed to a lack of certainty and understanding in the nature of professional knowledge in health visiting which has prompted the need for development of new epistemology of practice.

## The nature of health visiting knowledge and the development of an epistemology of practice

Robinson (1985) suggests that there are two fundamental issues which require addressing in the analysis of the nature of health visiting knowledge which in turn will influence the interpretation of practice. The first relates to the profession's commitment to the 'abstract notion of health' which she argues is a 'concept fraught with ambiguity which defies objective definition and quantification'. (Robinson 1985 : 67). This therefore provides a very fragile foundation for the basis of professional knowledge in health visiting. The other issue she attributes to the polarisation of the beliefs of practitioners which has created two conflicting paradigms of practice. One paradigm she argues is built on the belief that the concept of health visiting can be operationalised, measured and quantified and thus considered scientific; the other is based on the belief that the concepts of health visiting are unique and particular to each individual situation. This conflict in the basic philosophy of health visiting practice supports Robinson's argument for the need for greater analysis of the conceptual origins of strategies in health visiting practice before the profession can make any significant progression in its understanding of professional knowledge.

However, considerable time has been spent by those involved in health visiting attempting to understand the nature of practice. A major contribution to the debate was made by the working party established by the Council for Education and Training of Health visitors (CETHV) in 1975. Following debates with practitioners,



managers and educationalists four principles were identified which were described as reflecting the process of health visiting:

the search for health needs

the stimulation of an awareness of health

the influence of policies affecting health,

the facilitation of health enhancing activities (CETHV 1977).

Although these principles are grounded in the rather ambiguous concept of health, the political dimension of practice is implicitly demonstrated in this statement which Robinson (1985) argues is a dimension of practice unique to health visiting. This political dimension to practice was also identified in the evidence provided for the Community Nursing Review by the HVA. The HVA describe health visiting as empowering 'people to take responsibility for health as individuals, families and communities and thereby helps to prevent and minimise the effects of disease, dysfunction and disability' (HVA 1985 : 15)

The recent discussions on the future of health visiting practice stimulated by the HVA and Project 2000 have developed this issue further. Health promotion is described as 'much more than the individual health teaching undertaken by health visitors...Health visitors are quite properly expected in addition, to be able to search out and document unmet health needs within a community, to design an appropriate programme of care for the client community, to implement it and evaluate the outcomes' (Ayton 1987 : 34). Project 2000 describes the effective promotion of health requiring a 'highly developed level of knowledge, and skills, time and a particular singlemindedness' (UKCC 1986 : 51). The Community Nursing Review (DHSS 1986) also considered the concept of health promotion,

particularly in its analysis of the ways in which community nursing met the needs of the consumer, and identified the need for practitioners to enable individuals to make decisions about their own health based on informed choices. However, the evidence also illustrated that the very traditional patterns of practice frequently prevented practitioners from working with client groups most in need of effective health promotion. This evidence not only demonstrates the conflicting paradigms of practice currently in existence but also the difference between the theory of health visiting and the reality of the practice setting.

Within this brief review of the definitions and analysis of health visiting, the difficulty of defining and indeed the appropriateness of defining a body of professional knowledge unique to health visiting has been considered. England (1986) argues that a similar pattern exists in social work practice and states that social work will never acquire a body of knowledge exclusive to its practitioners. However he argues that the "social worker's 'practice knowledge' is his understanding of his clients, it is this unique understanding which informs and determines his helping". (England 1986 : 34). He goes on to argue that an essential component of this 'practice knowledge' is the intuition of the practitioner and his intuitive knowing in practice by which he makes sense of the unique practice situation. He places the emphasis on the practice situation rather than the body of knowledge which controls the individual's practice. This concept is developed by Schon (1983) who attributes the crisis in confidence in professionals to those practice phenomena which he describes as complexity, uncertainty, instability, uniqueness and value conflict. It is the intuitive knowing in practice by which practitioners make

sense of the practice setting to inform professional judgements from which strategies in practice are determined which Schon describes as the concept of professional artistry and considers fundamental to competence in practice. Indeed he goes on to argue that the relationship between professional knowledge and practice competence, and the artistry and intuition by which competent practitioners handle these phenomena in practice should provide the focus for research and learning in professional practice. A similar argument is presented by Robinson (1987 : 22) who suggests that the uncertainty in health visiting results from an over sophistication in its search for a theoretical base, while practitioners are reluctant to admit the importance of those characteristics described as 'non-judgemental, empathetic and relating on a moment to moment basis'. Indeed she highlights the need for practitioners to perceive practice as both an art and science rather than being mutually exclusive. (Robinson 1982) This conclusion supports the argument presented by Schon (1987) of intuition and artistry being fundamental in the process of professional judgement and yet one of the most complex aspects to understand in professional practice.

The need to consider issues such as practice phenomena, the artistry and intuition involved in professional judgement and the lack of a definitive body of professional knowledge, demonstrates the incongruity in attempting to develop a base of systematic scientific knowledge in health visiting and therefore invalidates any attempt to develop an epistemology of practice based on a model of technical rationality. Schon, (1983) however, argues the need to develop an epistemology of practice which reflects the reality of the practice setting and incorporates the concept of professional artistry. He argues that competent practitioners frequently know more than they

articulate about their practice and have the capacity to reflect on their intuitive knowing, whilst in the midst of practising. Therefore he argues that it is possible to develop an epistemology of practice which evolves from protocols of actual performance. The processes involved in constructing and testing models of knowing in practice he refers to as reflection-in-action. This approach to an epistemology of practice would facilitate practitioners in health visiting to establish methods of practice which allow for the uniqueness of the practice situation. It would in addition address the fundamental issue of assessing competence in practice and is particularly relevant to the current criticisms of professional education which clearly identify the gap between theory and the competencies required of practitioners in the field.

The assessment of professional competence in health visiting education: the implications for the interpretation of professional practice

Schon (1987) attributes the general crisis in confidence in professional practice in part to the gap between the educationalists' perception of professional knowledge and the actual competencies required of practitioners in the field. This argument has been supported in health visiting by the evidence presented in recent child death inquiries where specific areas of incompetent practice have been identified. Robinson (1987) argues that consumer studies in health visiting reveal the discrepancy between consumers' and practitioners' perceptions of individual health needs which has resulted in a significant degree of dissatisfaction with the service. White (1987) suggests that it is no longer appropriate to think in terms of a single role for the health visitor as this

varies significantly within different Health Authorities and communities and the earlier analysis of the different paradigms of health visiting practice supports this observation. She goes on to argue that it is unrealistic to expect professional education to prepare students to fulfil all these different roles and that it must prepare students to observe and recognise the diverse needs of their clients and the ability to develop strategies to meet those needs. These issues therefore raise not only the question of what is understood by professional knowledge and therefore the interpretation of professional practice, but also questions the methods used to assess competence in practice.

Schon (1987 : 33) argues that the model of technical rationality traditionally used to define competence in practice has contributed towards the current dissatisfaction with professional practice. The earlier discussion illustrates the incongruity between a model of technical rationality and the nature of health visiting practice. Similar conflicts arise from the definition suggested by Jarvis (1983 : 35) who despite acknowledging it unwise to define professional competence in objective terms identifies three specific elements; knowledge of an academic discipline which underlies professional practice; the skills involved in the performance of the professional practice; and the professionalism in attitudes of the practitioner. Although this provides broad parameters for a definition for health visiting, individual practitioners still have to establish a consensus of knowledge, skills and attitudes considered appropriate to health visiting. However, more significantly it does not address the concept of professional artistry.

Benner (1982 : 304) defines competence as 'the ability to perform the task with desirable outcomes under the varied circumstances of the real world'. She goes on to describe the difficulties that have occurred defining competency in nursing and argues that it is based on expert opinion rather than on the observation, description and analysis of actual nursing performance. Pottinger (1975) argues that competence is not a narrowly described set of cognitive measures but involves the ability in critical thinking, problem solving and the application rather than storing of knowledge. He states that 'it is abilities and characteristics such as maturation, perseverance, dedication and integrity that separate the more competent professional from the rest of their colleagues.' (Pottinger 1975 : 12). Therefore he argues that the three broad dimensions of competency are: the ability of an individual to process new information for problem solving, the ability to, integrate this information to form new solutions, and the ability to effectively implement these solutions.

Although this definition goes some way towards meeting the needs of health visiting practice, once more it does not address the fundamental component of competent practice contained in the concept of professional artistry. It is the practitioner's intuitive knowing in practice in making professional judgements, guided by her ability to make sense of unique practice setting which has become the central issue in professional practice. Indeed some critics argue that 'the most important areas of professional practice now lie beyond the conventional boundaries of professional competence' (Schon 1987 : 7), thus demonstrating the tortuous process of achieving an appropriate definition of competent practice. This has implications for the learning and assessment of student

practitioners who must not only demonstrate competence in professional knowledge and skills but must also demonstrate their competence in the indeterminate zones of practice described as within the concept of professional artistry. I would suggest this has a particular relevance to health visiting education, particularly when past evidence demonstrates that practitioners have been dismissed from practice due to a breakdown in professional relationships resulting from 'an excess of zeal, and lack of judgement, sensitivity and tact' (Industrial Tribunal 1983 : 3).

The process of assessing competence in practice in health visiting, in addition to meeting the demands of the Statutory Instrument which require the health visitor to develop the competencies for:

- "a) Co-ordination of skills in health assessment, identification of need, planning, implementation and evaluation of health education and care;
- b) Co-operation with persons engaged in a wide range of primary health care and other colleagues;
- c) Encouragement of and community participation and use of voluntary workers in health enhancing activities" (Statutory Instrument 1983 : 13), must also address the issue of the concept of professional artistry which has been identified as a fundamental element of professional practice. Although the above competencies implicitly reflect some of the phenomena which make up the concept of professional artistry, I would argue this demand creates a crucial dilemma in assessing competence in practice which is augmented by the assessment procedure.

Butcher (1968 : 137) describes the validity of an assessment procedure 'as the extent to which it does what it is designed to

do'. He goes on to state that difficulties arise when the criterion on which the assessment is based is not sufficiently explicit or distinctly nebulous or cannot be agreed. The difficulties in identifying appropriate criteria for an assessment procedure have been highlighted in the foregoing discussion on the conflicting paradigms of health visiting practice. However a much more fundamental issue relates to the extent to which the assessment procedure distinguishes between the student who is competent at a mechanical level but is unable to recognize when her practice is inappropriate, and the student who has the ability for reflection and analysis of her practice and attained an appreciation of the concept of professional artistry essential for developing strategies appropriate to the individual practice setting. The procedure may be additionally complicated by the understanding of professional knowledge and consequently the interpretation of practice demonstrated by the practitioner responsible for the process of assessing the student's competence in practice. The Fieldwork Teacher (FWT), who is responsible for this process in health visiting education, may not only have adopted a traditional paradigm of practice but also not attained an appreciation of the concept of professional artistry which has particular implications for the assessment of competence in practice.

The individual practitioner's understanding of professional knowledge, her interpretation of practice, her understanding of professional competence and the criteria selected for the assessment process are all significant in the process of assessing the performance of the student health visitor. The crisis in confidence in professionals and the significant proportion of clients dissatisfied with their experience of health visiting practice



question the extent to which the current assessment methods adequately address the issues of competence in practice. The issues outlined above provide the focal point of this study and the initial focus of a review of the current methods used to assess competence in practice of student health visitors.

- (1) The Infant Mortality rate is the number of deaths of children under one per 1000 live births.
- (2) National Standing Conference was established in 1945 to enable health visitor lecturers to consider questions relating to the selection, training and examinations of student health visitors. Although the remit has changed during the intervening years it remains a forum for discussing issues and initiatives in health visiting education and training.
- (3) This evidence has been obtained from material presented at a meeting of lecturers and nurse managers and from discussions amongst lecturers at both National and Regional Standing Conferences.
- (4) These schemes were originally initiated in 1956 and expanded in the 1960s. The scheme involved the health visitor being professionally accountable for the clients registered with a specific General Practice and it was anticipated that the 'attachment' of a health visitor to a specific G.P. practice would improve interdisciplinary collaboration (Hicks 1976).
- (5) The United Kingdom Central Council was established by the Nurses, Midwives and Health Visitors Act 1979. Its principal functions are: to establish and improve the kind and standards of training and professional conduct for nurses, midwives and health visitors and to determine the conditions and rules for professional registration.

## CHAPTER 2

### Assessing Competence in practice: the state of the art

The issues raised in the debate in Chapter 1 highlight the difficulties in designing a valid procedure for assessing competence in health visiting practice. The assessment process must not only demonstrate the practitioners' understanding of professional knowledge and interpretation of practice but also distinguish between the student who functions at a mechanistic level (failing to recognise inappropriate practice), and the student who is able to analyse and reflect on her practice and demonstrate an appreciation of the concept of professional artistry. Indeed I would argue that the current crisis in confidence in health visiting (Robinson 1985, Greenwich L.B. 1987, Goodwin 1988) and the significant proportion of clients who have expressed dissatisfaction with their experience of health visiting practice (Foxman 1982, Clark 1984) substantiate the difficulties experienced in designing and implementing a valid assessment procedure. The examination results in health visiting which currently present a mean pass rate of 96% (Thwaites 1986) raise further questions about the validity of the procedure particularly when compared to a mean pass rate of 73% in general nurse education which has an additional student wastage rate of 15% (ENB 1987). The high pass rate in health visiting education was initially demonstrated in a study undertaken to investigate the correlation between the examination results of different training centres (Fader 1976). This phenomenon was attributed to three main factors:

the intensive selection procedures employed by both health

authorities and educational institutions, the close link between courses and the educational advisors at the CETHV (1) and the system of course approval (Fader 1976:xi). The mean pass rate during the study years of 1973-75 was 96% and as previously identified this trend has continued. The questions raised by the high pass rate must not only include the validity of the assessment procedures but also the validity of the selection procedures and the level of student motivation and commitment. Simpson (1972:119) comments that students in higher education are "a highly self selected and pre-selected group", and indeed a similar pattern is demonstrated in health visiting. Robertson (1982) has likened the acquisition of a qualification in health visiting to "an obstacle course" and this observation is substantiated by the admission procedure. Dobby (1984) describes the difficulty encountered by students in obtaining places to undertake the course and attributes it not only to the admission criteria but also to the general requirement for secondment or sponsorship by a Health Authority. At the time of the empirical work in order to fulfil the entrance criteria the applicant had to have obtained the following qualifications;

- i) Registered General Nurse,
- ii) Registered midwife or an obstetric qualification approved by the appropriate National Board,
- iii) Five subjects at ordinary level in the General Certificate of Education or equivalent (Statutory Instrument 1983:12). The additional difficulty in obtaining secondment or sponsorship has also been demonstrated. Dobby (1984) cites the case of the candidate whose application for sponsorship had been processed by nine Health Authorities before the student was finally successful. Although this may reflect the motivation of the candidate I would

suggest it may support the findings of Dellar (1981) and Ray (1979) which question the validity of the selection procedures in health visiting, thereby highlighting the significance of the process implemented to assess competence in practice. However it is interesting to note that the Health Visiting Joint Committee (HVJC) (2) have expressed concern at the decline in the available funding for health visitor students and has suggested three contributing factors: the 1982 NHS reorganisation, the priorities selected by health authorities for the training of staff and the lack of available employment in the seconding health authority following training (HVJC 1984). The committee also suggested that where health authorities were prepared to second or sponsor suitable applicants to undertake the required obstetric course, the available budget for health visiting training was reduced. It has been demonstrated that of the 2786 applicants for health visiting in 1981-82, 1281 (46%) were successful in commencing the post registration course in the autumn of 1982 (Dobby 1984). Dobby's research showed that this typical pattern for enrolment continued in 1983. Although I would suggest the evidence cited above may indicate the level of commitment and motivation of the student, it does not address the phenomenon of high pass rates in relation to the level of client dissatisfaction and the professional crisis in confidence in health visiting. This once more raises questions about the validity of the assessment procedure, particularly in assessing the student's attainment of an appreciation of the concept of professional artistry.

The assessment of competence in practice is additionally complicated by the interpretation and understanding of the process of assessment by those involved in designing and implementing the

procedure. The process of assessment has been defined in various ways, however, Rowntree (1977:4) describes it as "occurring whenever one person, in some kind of interaction, direct or indirect, with another is conscious of obtaining and interpreting information about the knowledge and understanding or abilities and attitudes of that other person."

This definition is particularly pertinent to health visiting practice as it includes both formal and informal methods of assessment and considers both the cognitive and affective domain of learning. Indeed if the student is to be assessed in her ability to observe and recognise the diverse health needs of clients and develop strategies to meet those needs there must be particular emphasis on the affective domain. In addition, the importance of both attitudes and interpersonal skills in health visiting practice have been described (Orr 1980, Swain 1983, Foxman 1982) and undoubtedly play a fundamental role in the intuitive knowing in practice by which practitioners make sense of the practice setting to inform professional judgements which determine strategies in practice. This once again emphasises the importance of the affective domain in the process of assessment. Rowntree's definition goes on to suggest that assessment is a two way process. This has implications in health visiting education as the student's assessor is also her teacher and the assessment process may indicate the FWT's knowing-in-action and ability to "travel freely on the ladder of reflection" (Schon 1987:164) particularly when the student and FWT become caught in a learning bind. Indeed Schon goes on to argue that the phenomenon of a learning bind (which he describes as failure by the student and FWT to recognise that they have missed each others meaning in the reflection in the dialogue)

may dictate the learning outcome achieved by the student.

The interpretation and understanding of the process of assessment will also be influenced by the assessor's perception of the purpose of the procedure. Heron (1981:9) argues that assessment has a dual purpose, firstly to provide the student with feedback of her performance during the course and secondly to provide a certificate of competence for her professional role. The provision of feedback is obviously important for both the student's personal and professional development. This is particularly so for adults since an andragogic philosophy of education acknowledges that the student's motivation to learn will be determined by an awareness of a learning need (Jarvis 1983). During the course this feedback will be provided by the FWT, the lecturers and clients. The use of a formative approach in assessment enables the procedure to act as a diagnostic tool identifying the strengths and weaknesses of the student in both the theoretical and practical component of the course. However, Heron (1981) maintains that self and peer assessment are vital in the process of student feedback and are skills which the students should develop in their professional education. I would suggest these skills are particularly important in health visiting as once qualified practitioners currently work in relative professional isolation. In addition the practitioner will need to employ these skills in the process of reflection-in-action. The provision of a certificate of competence provides a method of controlling professional standards in practice. However, I would suggest that this function of assessment is constrained by the assessor's understanding of professional knowledge and interpretation of practice and in reality may exert very little control over standards of practice.

A third purpose of assessment has been identified as controlling the number of practitioners entering the profession. However, with the high pass rates experienced in health visiting education and the problems of low recruitment (HVJC 1984) I would suggest that few assessors perceive this as a purpose of the assessment process.

Another factor influencing the interpretation and understanding of the process of assessment is the design of the procedure. Miller and Parlett (1974:14) describe four stages: the actual preparation of the procedure by one or more members of the staff, the presentation of the "assessment task" to the students for completion within defined parameters, the appraisal of the completed work by appropriate staff and the judgement following evaluation being communicated to the appropriate individual (the student, other members of staff and the examination board). I would suggest that this pattern is used in the preparation of the theoretical component of the course. The assignments are prepared by the lecturers responsible for teaching that component of the course and these are then moderated by both internal and external examiners at the Examination Board. It is interesting that although these stages apply equally to the practical component of the course, it is my belief that the procedure is frequently only prepared by the lecturing staff which means that the practitioner undertaking the process (the FWT), has little or no input into the preparation of the procedure. This has implications for the understanding of professional knowledge and the interpretation of practice and the validity of the assessment procedure. Heron, (1981), although describing four stages in the process, suggests an alternative model. He states that the first stage must consider what to assess: whether the process or the product. This has

particular relevance for the current concerns expressed in health visiting education, since the assessment procedures are frequently designed to assess the product rather than the process and the previous discussion in Chapter 1 highlights the inappropriateness of thinking in terms of a single paradigm of practice. Indeed if the practitioner is to develop the ability to reflect-in-practice the processes employed by the student must be a central component of the assessment procedure. The second stage he identifies as selecting the criteria used in the procedure, the third stage considers the application of those criteria and the fourth stage involves actually carrying out the procedure. Although I would suggest Heron's design is more appropriate to the needs of health visiting practice, when attempting to implement either model in the assessment procedure, the inherent problem identified in Chapter 1 (that of the selection of appropriate criteria to identify competence in practice) remain. I would argue this phenomenon contributes to the current crisis in confidence in professional education and client dissatisfaction with the service. In addition the structure of the procedures is constrained by the requirement of the National Board (3) and raises the question once more of whether the current procedures attempt to measure a body of knowledge or the student's ability to develop strategies to meet diverse health needs of clients in the individual practice setting. It is these factors which I would suggest raise questions as to the extent to which the current methods of assessment adequately address the issue of competence in practice and led to the review of the assessment processes that were in use at the time of the empirical work.

The English National Board (ENB) require the assessment process to



consider not only the theoretical and practical components of the course but also the two distinct parts of the course. Part one consists of three academic terms, with one third of the time spent in fieldwork practice (CETHV 1982) and is followed by the Intermediate Examination Board. The final Examination Board follows part two of the course which consists of a period of supervised practice of a minimum of nine weeks. The theoretical component involves the assessment of the five sections of the syllabus: 'the development of the individual, the individual in the group, the development of social policy, social aspects of health and disease and the principles and practice of health visiting.' (CETHV 1982). Although the assessment process must include two unseen examination papers the ENB approval procedure permits institutions to present different models to assess the above syllabus. Therefore for the purpose of exploring whether the current theoretical assessment procedures can be considered as a valid method of assessing competence in practice I have drawn upon my own professional experience and described the model used in the case-study college at the time of the empirical work. The sections of the syllabus 'social aspects of health and disease' and 'the principles and practice of health visiting' were both assessed by a three hour unseen examination paper. 'The development of the individual' was assessed by three essays spread throughout the academic year. 'The individual in the group' was assessed in a similar way requiring the students to submit two essays during the second term. 'The development of social policy' was assessed by a seen paper which involved writing a prepared essay on a selected topic under examination conditions. All the questions set for these assessment procedures were moderated by the internal and external examiners. In order to proceed to supervised practice,

the students must have successfully completed the intermediate assessment procedures for at least three sections of the syllabus and have received a satisfactory report on their performance during the year (ENB 1982). Although this is provided by a lecturer in health visiting it must incorporate the assessment made by the FWT of the student's performance in practice.

The process of assessing the practical component of the course is also determined by the ENB and four specific components must be considered: the period of fieldwork practice, the "health visiting and neighbourhood" studies, the period of supervised practice and the oral examination. It is interesting that although the ENB provide a structured assessment procedure for supervised practice (Appendix A) this does not occur in fieldwork. Indeed each institution is responsible for designing and implementing their own assessment procedure and this is discussed in depth in Chapter 6. Although the "health visiting and neighbourhood" study are a theoretical piece of work, the content is based on the health visiting intervention offered by the student to a particular client or family and therefore reflects the student's competence in practice. For the period of supervised practice the student is placed in her seconding or sponsoring health authority and as in fieldwork practice, it is the responsibility of the assessor to provide both the learning experience and undertake the process of assessment. The oral examination, which lasts approximately twenty minutes, is held at the end of supervised practice and is undertaken by not more than three examiners (both internal and external). The "health visiting and neighbourhood studies" provide the framework for this procedure. Following the student's successful completion of the final assessment the course director

is required to sign a declaration of character stating in her opinion the student is a fit and proper person to be admitted to the professional register (Appendix B). The validity of this declaration has created some conflict amongst those involved in health visiting education (Regional Standing Conference 1987). Indeed I would generally question the extent to which the current procedures are valid in assessing competence in practice since the procedures must not only address the students' understanding of professional knowledge and interpretation of practice but also the intuitive knowing in practice by which practitioners make sense of the practice setting to inform professional judgements which determine strategies in practice: the concept of professional artistry. These issues therefore require addressing in this review of the current assessment procedures.

#### The current assessment procedures: a valid process in assessment

The information provided above demonstrates the variety of methods employed in the procedures used to assess the professional competence of students in both the theoretical and practical component of the course. Although my research interest relates particularly to those methods used to assess competence in practice this review must include those procedure used in the theoretical component as this also reflects the students understanding of professional knowledge and interpretation of practice and obviously forms an integral component of the qualifying procedures. It is my belief that many educationalists place a much greater emphasis on the theoretical component, particularly at the stage of the intermediate examination. This I would suggest has implications

for the process of assessment particularly in relation to the discrepancy between the theory of health visiting and the reality of the practice setting, thereby raising once more the issue of professional competence and the interpretation of practice.

### The use of continuous assessment in the process of assessing competence in practice

Before exploring the validity of continuous assessment as an procedure in assessing competence in practice it is important to establish the context in which this term is being used. Rowntree (1977) differentiates between course work submitted for examination purposes and that submitted for the student to obtain informal feedback on their strengths and weaknesses. Although the latter is a valuable diagnostic tool in adult learning in both personal and professional development it does not contribute to the formal assessment procedure. Therefore, continuous assessment in health visiting education refers to coursework which is undertaken during the academic year and is an essential component of the intermediate examination.

The attributes of this method of assessment have been generally recognised in nurse education (Spencer 1985) and indeed it is used extensively in health visiting education. A particular advantage of continuous assessment is that it provides the student with the opportunity of exploring a topic in depth: a fundamental stage in the process of reflection-in-action if the student is going to achieve a substantive understanding of the processes to which the practice issues relate. It also provides the student with the opportunity of discussing the topic during tutorials and therefore

entering a reflective dialogue with the lecturers. This also enables the revision of drafts before the final submission which is particularly important in adult education. Indeed, Gibson and Jarvis (1981:481) argue continuous assessment provides the less academically experienced with the opportunity of achieving higher levels of performance and this is particularly pertinent when the educational experience and academic achievement of the students at the beginning of the course ranges from the minimum entrance requirement to an honours degree. It also overcomes the problem of speed writing and long term memory recall, both of which can be particularly stressful to adult learners (Child 1981).

However, I would suggest that a particular advantage of continuous assessment is that it provides the students with the opportunity of demonstrating their ability in analysing, synthesising and evaluating their understanding of professional knowledge. This process is essential if the understanding of professional knowledge is to encompass the concept of professional artistry, as well as enabling the students to develop the ability to articulate their practice so they can construct and test modules of knowing-in-practice, thereby developing an epistemology of practice grounded in reflection-in-action. Another important advantage of this method of assessment is that it provides the student with continuous feed-back on their performance. This again, is particularly pertinent in adult learning where research has demonstrated the extreme anxiety experienced by individuals in their ability to cope with an intensive course of study (Jarvis and Gibson 1980). It also allows individuals to plan their assignments around family commitments, which is essential in a student group where 99% of the intake is female and a significant proportion of

the students have dependent children. (CETHV 1983).

However, studies have also demonstrated the disadvantages associated with continuous assessment and these must be considered. Miller and Parlett (1974) and Dingwall (1977) demonstrate that some students found the level of stress generated by the continual production of assessed work unacceptable. Other difficulties arise when students become obsessed with negotiating assignments and grades, thus inhibiting their professional development in other spheres of the course (Dingwall 1977). Some students expressed concern that assessors may have higher expectations than in an unseen written paper. Some writers argue that continuous assessment may also hinder the relationship between the student and teacher. However Nuttall (1981) disputes this, stating that the increased motivation of the student creates a feeling of the student and the tutor working together towards a common goal. This method of assessment also allows the student to 'cue-seek' (Miller and Parlett 1974). 'Cue-Seeking' relates specifically to those students who are not only perceptive and receptive to cues given by the staff about issues such as the appropriate interpretation of a topic, but actively interact with the staff to obtain this type of information or attempt to make a good impression. Whether this is considered inappropriate is debatable, however it may unfairly advantage those students who perform in this way. Another disadvantage which has been identified is the possible question of the authenticity of the students' work, particularly where the award is a statutory qualification. However I would suggest that the principal disadvantage remains the subjectivity of the assessor in marking the assignment. This may result from the student being known to the assessor, therefore prompting the 'halo-effect' or

indeed the reverse phenomenon but it may also depend on the interpretation of professional practice preferred by the examiner. However a more obvious cause is the general difficulty of subjectivity associated with the marking of an essay type assignment (Cox and Ewan 1982). However this remains a disadvantage with all methods of assessment using this type of response.

Therefore although I would argue continuous assessment is a more appropriate method of assessing the adult learner in professional education it does not necessarily provide a valid procedure for assessing competence in practice. This depends not only on the understanding of professional knowledge and interpretation of practice on the part of the assessor but also on the ability of the assessors to prepare assignments which are valid for assessing the required outcome of professional education. In order to resolve the current crisis in health visiting I would argue that the procedures must equally assess the student's ability to reflect-in-action and her appreciation of the fundamental role of the concept of professional artistry in competent practice, rather than attempt to assess a specific body of professional knowledge. This highlights once more the significance of assessing the process rather than a specific paradigm of practice and I would therefore question the extent to which the procedures at the time of the empirical work could be considered a valid assessment procedure.

## The use of examination papers in the process of assessing competence in practice

### The use of unseen examination papers

The discussion earlier in the chapter demonstrated that the ENB require at least two of the procedures in the intermediate assessment to consist of unseen examination papers. One justification for the inclusion of this form of assessment is that it may resolve any doubts about the authenticity of the students' work. It is also considered that this will benefit those students who perform better in a final unseen paper than in continuously assessed work (Thwaites 1985). However there are considerable disadvantages in using this method of assessment in professional education, particularly when assessing an interpretation of practice which acknowledges an epistemology of practice grounded in reflection-in-action.

Cox and Ewan (1982:195) argue that an unseen examination only tests the student's acquisition of knowledge and the assessment only provides a demonstration of an ability to recall and reproduce this knowledge in the specified time. Additionally, it does not facilitate the assessment of skills or attitudes which are equally important to competence in practice nor more significantly the students appreciation of the concept of professional artistry. Fader (1976) demonstrated that unseen examinations in health visiting only assessed the students' ability in the comprehension and recall of knowledge and did not demonstrate the levels of analysis, synthesis and evaluation. Authors such as Schon (1987) and Heron (1981) argue that the competent practitioner must



demonstrate the ability to critically evaluate their performance. However I would suggest this may once more reflect the ability of the assessor in preparing questions which assess the required levels of knowledge rather than the inadequacy of the procedure, and indeed the use of problem solving case histories have been introduced in nurse education to overcome this difficulty (Boreham 1977, Crow 1980).

The problem of subjectivity in marking by the assessor has also been demonstrated in the use of unseen examination papers. Research undertaken by the National Foundation for Educational Research demonstrated the discrepancy in grades awarded to students (Nuttall 1981). Research in health visiting education has also demonstrated that students who might be successful at one centre may fail elsewhere due to inconsistency in marking standards. Students were also able to obtain higher marks than members of their peer group, who demonstrated equal attainment, simply by choosing a different set of questions. This was despite the moderating process of the external examiners (Fader 1976), and therefore raises questions about the validity of using unseen examinations as a method of assessing competence in practice.

Nuttall (1981) argues that students may be further disadvantaged in their performance in unseen papers because of either a physical or emotional disturbance in their health at the time of the assessment. This is particularly relevant where there is a high proportion of mature students who may be adversely affected by the stress of an unseen paper. Simpson (1972) relates this argument to the physiology of women and describes the work by Dalton (1968) which demonstrated women obtained lower grades during the menstrual

and pre-menstrual period. Again these factors may be applicable for students in health visiting. The additional fact that unseen papers are usually a summative assessment, with the papers not being returned to the students negates a vital function of assessment, that of providing the student with feed-back on their performance and is particularly significant in the field of professional and adult education.

#### The use of seen examination papers

At the time of the empirical work the students in the case-study college were required to complete one seen examination paper. This involved the students being given the paper five weeks before the examination date, having to select one question from a choice of four, and being allowed to take a prescribed amount of notes into the examination room with them. Rowntree (1977:134) argues that the seen question paper gives the student the opportunity of thinking critically about the topic and therefore demonstrates the students' ability to analyse, synthesise and evaluate their understanding of professional knowledge. In addition the seen examination paper allows the student to consider the topic in a stress free situation, thus preventing a limited or misinterpretation of the question. It also means the students have access to tutorial help, thus permitting 'cue-seeking' in those students who are willing to participate in this educational system. However it still necessitates the students reproducing the material in examination conditions, thereby failing to avoid the disadvantages previously described. In addition the student is required to use long term memory recall and to write as much material as possible in the time available, and it once more fails

to provide the students with essential feed-back on their performance. The examiner may also have higher expectations of the students' performance and it does not resolve the problem of subjectivity in marking an essay type examination paper. I would suggest therefore that there are few advantages in using this method with mature students as many of the disadvantages are experienced equally with unseen papers.

These arguments support those suggested by Fader (1976:99) who states that unseen examinations are an inappropriate method of assessment in health visiting education particularly when the high pass rate is taken into account. Indeed she argues that the selection process plays a fundamental role in the qualifying procedure. In support of this argument I would suggest that a selection process which addresses the issues which influence the student's ability to attain an appreciation of the concept of professional artistry, supported by a programme of continuous assessment would provide a more valid procedure to assess the students' competence to reflect-in-action. However if the ENB maintain the requirement for two unseen examinations I would argue that further research is necessary to establish procedures which will assess the processes employed by the student in professional practice and to analyse, synthesise and evaluate the understanding of professional practice. But I would argue that a major concern remains in that these procedures will still not assess the intuitive knowing in practice by which students make sense of the unique practice setting to inform professional judgement and determine strategies in practice: a view which is substantiated by the research into the consumers' perception of health visiting identified in Chapter 1 (Foxman 1982). I would suggest this

evidence demonstrates the need for greater emphasis to be placed on those methods used to assess the practical component of the course particularly as this relates directly to the students' competence in practice.

The current methods used to assess competence in practice in the practical component of the course

It is the practitioner in the field who currently has the main responsibility for assessing this component of the course. However a principal difficulty in the procedures used in this process is the involvement of the assessor in direct observation of the student's performance. Wood (1982:11) argues that any human observation is a subjective process and 'exhibits inherent bias'. Paradoxically difficulties arise because the student's performance is often not directly observed, and the assessment takes place in an indirect manner, using information supplied to the assessor by the student and other informal networks, such as colleagues and clients, which again raises questions about the validity of the assessment process. An additional difficulty is created by the conflicting paradigms of practice adopted by practitioners thereby causing a discrepancy in the interpretation of professional practice demonstrated by the student and the assessor. Robinson (1987) argues that despite the searching for a theoretical base for health visiting practice it is those attributes of the practitioner described as 'non-judgemental, empathetic and relating on a moment to moment basis' which are fundamental to competent practice. Indeed England (1986) argues that the intuitive knowing by which the practitioner makes sense of the unique practice setting and uses that knowledge to inform practice is a fundamental component

of professional knowledge. This argument supports that suggested by Schon (1987) that an epistemology of practice must not only reflect the reality of the practice setting but also incorporate the intuitive knowing in practice by which practitioners make sense of that setting to inform professional judgements and determine practice. Therefore the review of the methods used to assess the students' competence in practice must consider these different but equally important domains of practice.

The ENB, although requiring fieldwork practice to be assessed, does not provide a specific procedure and therefore the following review relates to the process of assessment in use in the case-study college at the time of the empirical work.

#### The period of fieldwork practice

It is during fieldwork practice that the first stage of the process of assessing competence in practice takes place and this is undertaken by the FWT who is also responsible for providing the learning experience for the student. It is during this experience that the FWT must not only provide the student with the opportunity of learning the science of practice but also of achieving an appreciation of the artistry of practice and more significantly the interplay between these two domains of practice. These issues are explored in depth in Chapter 6. However although this learning experience will vary with individual FWTs, the pattern of fieldwork practice also varies with individual colleges. In the case-study college the students spent one day a week with their FWT during each academic term, with an additional two week block placement in both the autumn and spring term. The ENB require fieldwork experience to equate to one third of the students' training during

part one of the course and at the time of the empirical work it was recommended that the FWT completed a formal assessment on the student's progress each term (CETHV 1982:22). However due to the limited experience available in the third term, the FWTs were only required to complete two formal assessments, one at the end of the first term and one during the third term. The final assessment includes a statement from the FWT stating whether in her opinion the student is ready to proceed to part two of the course: supervised practice. Indeed the ENB require that this statement forms one of the criteria which must be met if the Examination Board is to recommend that the student proceeds to part two of the course.

However the assessment of competence in professional practice is a complex process and the difficulties have been well documented in other caring professions particularly nursing, medicine and social work. These issues include the students' ability to relate theory and practice (Akhurst 1978, Hack 1973), the complexity of the assessment process (Squier 1981, Wood 1982), the possibility of devising and using rating scales and check-lists in an attempt to increase objectivity (Boreham 1978, Cox & Ewan 1982, Morrell 1980) and the validity and reliability of the supervisors assessment of their student (Dobby 1981, Feletti et al 1983, Davies 1979). Despite there being little available literature in health visiting Dean (1981) describes a similar dilemma in the assessment of competence in student health visitors. She argues that as the FWTs found difficulty in defining criteria for competence in practice 'the assessment of a student is largely intuitive on the part of the Fieldwork Teacher' (Dean 1981:216). It is interesting that this finding is substantiated by Chapman (1979) in her study of 62

FWTs. However I would suggest it is significant that 28 (45%) of the sample rated their performance in student assessment as only fair to poor. James and Loveland (1973) also argued the need for FWTs to have more specific criteria when assessing the competent practitioner, but went on to raise the question of whether it was more appropriate to have an objective evaluation of few specific qualities in the student or a more subjective evaluation of the whole person. However I would argue that these observations highlight the dilemma experienced by practitioners in the use of intuition and intuitive knowing in professional practice. This finding supports the argument proposed by Schon (1987) that practitioners refer to terms such as intuition as 'junk' categories since they refer to phenomena which elude conventional strategies of explanation and therefore instead of opening up inquiry close it off. Indeed I would argue that it is this phenomenon which has contributed to the difficulties experienced by practitioners in articulating an interpretation of professional practice which provides a framework for assessing competence in practice.

#### The assessment of supervised practice

Supervised practice is normally undertaken in the seconding or sponsoring health authority and must consist of at least nine uninterrupted weeks of health visiting practice (CETHV 1982). This assessment, together with the "neighbourhood study" and "health visiting studies" and the oral examination form the final assessment of the student's competence in practice. The aim of supervised practice is to provide the student with the opportunity to 'extend and deepen their experience and to test themselves within a framework allowing sufficient independence yet offering support and advice' (CETHV 1982:33). A nurse manager or an

experienced health visitor who has undertaken an approved course for assessors (4) is responsible for the student's supervision and assessment during this period, and this includes meeting regularly with the student to discuss their progress and professional development. The rationale for introducing this component in the revised course introduced in 1966 was to enable students to demonstrate their potential as practitioners (CETHV 1978). It is recommended that the workload (5) selected for the student consists of approximately 100 families, including clients of all ages from different social classes and cultural groups. The definition of a family unit includes both single parents and the elderly living alone. The selection of the workload is obviously more difficult in some health authorities where not all client groups may be represented. However I would argue that this requirement not only highlights a task orientated approach to the interpretation of professional practice but also the lack of a conceptual framework for practice. This in turn raises serious questions as to the extent to which students can consolidate their understanding of professional knowledge in a nine week period of practice.

The ENB provide a standardised procedure for the assessment of this part of the course which during the academic year 1984-85 included the use of rating scales measuring performance on a 4 point scale. The criteria selected for inclusion were: the organisation of work, home visiting activities, clinic management, group teaching and contact with other agencies. Another section included the student's ability to work with colleagues, the student's approach to work and clients, and the development of their professional role. These criteria once more highlight the task orientated approach to the interpretation of professional practice.



The final section of the procedure required the assessor to comment on the particular strengths and weaknesses of the student as well as requiring the signature of the student stating she had seen and discussed the contents and recommendations (Appendix A). It is interesting that very little is included within the procedure on the interpersonal skills of the student although it could be argued that this aspect of competence in practice had been previously assessed in the intermediate assessment. However I would argue it is more significant that the procedure in no way addresses the intuitive knowing in practice by which practitioners make sense of practice phenomena to inform professional judgement, thereby highlighting the restricted interpretation of professional practice. It is pertinent to note that considerable concern had been expressed in health visiting education about the use of this assessment procedure, particularly in the selection of criteria when establishing the baseline for the rating scales. (Smith 1985). This led to the formation of a working party at the ENB and the production of an amended assessment procedure. Although the structure of the procedure has changed to avoid the use of rating scales, the interpretation of practice remains task orientated, including specifically stated objectives. Therefore I would still question the validity of this assessment procedure (Appendix C), particularly in relation to the length of time of the period of supervised practice.

#### The assessment of the neighbourhood study and health visiting studies

At the time of the empirical work the students in the case-study college were required to submit a "neighbourhood study" and two

"health visiting studies". The aim of the health visiting study is to demonstrate the development of the student's practice by assessing the health visiting intervention offered to a particular family or client with whom the student has worked over a period of several months during fieldwork practice. It is anticipated that in addition to the studies demonstrating the attitudes of the student to different client groups and individual health choices, they should represent the FWTs' workload. I would suggest this demand for a client based approach to the studies highlights once more the lack of a conceptual framework to practice.

The Examination Board requires that each study should be approximately 3,000 words long and fully referenced. Students are permitted and encouraged to seek tutorial help from both their FWT and lecturers in health visiting on the selection of appropriate families and the writing up of the studies. The type of dialogue and process which occurs between the student and the teachers once more varies between courses and the implications of this to the validity of the assessment process is explored in Chapter 9. The "neighbourhood study" aims to provide the student with the opportunity of exploring the sociological and epidemiological aspects of the physical and emotional health of those clients within the FWTs' workload. It is expected that cross referencing occurs between the studies as the pieces of work are inter-related. These studies which are submitted at the beginning of the period of supervised practice, provide the basis for the oral examination which occurs at the end of supervised practice.

#### The use of the oral examination

The panel for the oral examination at the time of the empirical

work consisted in the case-study college of two examiners: an external and an internal examiner who were both lecturers in health visiting. The oral lasts for approximately 20 minutes and as previously described the material in the "neighbourhood" and "health visiting studies" provides the foundation for the assessment procedure. It is pertinent to note that up to ten weeks may have elapsed between the submission of the written work and the oral examination. The examiners may discuss any aspect of the studies which they feel reflects the health visiting intervention offered by the student. The student who has only achieved a borderline grade in the assessment of the studies is generally given the opportunity in the oral to defend her material and therefore acquire a pass grade in this section of the assessment procedure. Paradoxically it was possible at this time for a student who had been successful in the written assessment of her studies to be referred or fail in the oral examination, which I would suggest raises questions about the use of this assessment procedure. The oral examination is the final component of the assessment procedure for part two of the course and students who have successfully met the criteria for the final examination board are awarded the statutory qualification of the certificate in health visiting.

It is my belief that the assessment process used in the practical component of the course raises serious questions about the validity of the procedures used to assess competence in practice. My concern relates not only to the interpretation of professional practice from which criteria are selected to form the assessment procedures but also to the structural design of the assessment process. I would suggest that the current procedures are grounded

in a task orientated approach rather than the processes involved in health visiting practice. In addition the validity of the procedure will depend not only on competence and objectivity of the assessor but also on her understanding of professional knowledge and interpretation of practice. I would therefore suggest it is important to consider the relationships and professional grounding of those practitioners involved in the assessment process.

### The Assessors

Generally the assessor has a particular responsibility for assessing either the theoretical or practical component of the course. However in order to meet ENB requirements the lecturers in health visiting, in addition to their major responsibility in the theoretical component, play a significant role in assessing the practical component of the course. This is due to their responsibility for designing the assessment procedure used by the FWT and therefore has implications for the understanding of professional knowledge and the interpretation of practice demonstrated by the individual lecturer. Indeed I would suggest that the legitimate conflict experienced in the interpretation of professional practice has implications for the assessment process and therefore must be considered when reviewing the professional grounding and responsibilities of individual assessors.

### The Lecturers

Although the theoretical component of the course is assessed by the lecturing staff, the specific responsibility of individual lecturers varies within different institutions and therefore the described pattern applies explicitly to the lecturers in the case-study College. The five sections of the syllabus are examined

by the internal examiners and the assessment includes both seen and unseen papers using an essay style response. At the time of the empirical work the internal examiners consisted of a sociologist and lecturers in health visiting who had additional responsibility for subject areas such as psychology and human development. In order to be registered by the UKCC as a lecturer in health visiting the practitioner must meet the following criteria:

'a registered nurse with at least three years full time experience of nursing in the community of which two must have been as a practising health visitor, and have successfully completed a course of training as a lecturer in health visiting approved by the UKCC' (CETHV 1983b:1) As all the internal examiners work very closely with the students throughout the year, the problem of subjectivity when marking assignments must be considered. In an attempt to resolve this issue a double marking scheme was introduced, whereby student papers are marked separately by two internal examiners. However the risk of the 'halo-effect' in student performance remains. An additional safeguard is provided by the external examiner who has the responsibility of moderating both the questions set in the assessment procedures and the marking of the internal examiners. The external examiner must be approved by the National Board and is appointed for a period of three years. It is the external examiner and an internal examiner (who may be a lecturer in health visiting) who are responsible for assessing the student in the oral examination.

### The Fieldwork Teacher

The FWT is a registered health visitor with at least two years full time health visiting experience who has in addition successfully completed an approved Fieldwork Teachers course. The FWT has the

dual responsibility of providing the student with appropriate fieldwork experience and assessing the student's competence in practice. Although the amount of time the student spends in the fieldwork placement varies slightly with individual institutions it must correspond to one third of the course. In the case-study college this equated to 45 days, which I would suggest has implications for the effectiveness of the learning environment created in the practicum by the FWT. It is also during this period that the FWT is required to make both a formative and summative assessment of the student's performance. The implications of these issues in the assessment of competence in practice is explored in Chapter 6.

However during this period there are other demands made on the FWT which raise issues about the effectiveness of the practicum. Jarvis and Gibson (1985:7) describe the FWT being required to be an expert in two professions: both health visiting and teaching. This necessitates the practitioner keeping up to date with new developments in both areas of practice and in the limited time available to the FWT this presents a professional challenge. In addition, the FWT is professionally accountable to the clients in her caseload, and when trying to balance the needs of the student with those of her clients this may also result in a professional challenge. Indeed the demand for the FWT to be both the teacher and the assessor of the student may in itself cause conflict, particularly in relation to the concept of role modelling and the assessment process. The understanding of professional knowledge and the interpretation of practice adopted by the FWT may also influence the teaching and learning process. This specifically relates to the FWT's understanding and appreciation of the concept

of professional artistry which in turn may have implications for the validity of the assessment procedure.

#### The assessor of supervised practice

The period of supervised practice, as previously stated, generally takes place in the student's seconding or sponsoring health authority. Although it is the responsibility of nurse management to obtain a suitable placement for the student during this period it must be approved by the educational institution. However this means that the assessor has the responsibility for both providing the experience and assessing this component of the student's training. Although as previously described the period of supervised practice must be at least nine weeks in length, at the time of the empirical work the period was actually ten weeks. However, this once more provides a limited time in which the assessor can determine a formative and summative assessment of the students' competence in practice. For the student to benefit from the formative assessment constant feed-back is necessary and therefore the ENB requires the assessor to meet the student on a regular basis. However as anecdotal evidence suggests the degree of feed-back varies with individual situations. Lecturers in the case-study College attempted to overcome this difficulty by requiring the assessor to undertake a full written formative assessment not later than the fourth week of supervised practice. It was anticipated that this would facilitate the task of formally identifying the strengths and weaknesses of the student. As in any andragogic learning environment the student participates fully in this two way process and any concerns of either the student or the assessor are shared with the appropriate lecturer in health visiting. An additional difficulty in supervised practice is the

assessor's expectation of the student's performance. The student may be adjusting to a different paradigm of practice from that experienced during the practicum, and therefore demonstrating poorly developed skills in certain aspects of practice. I would suggest that in this situation particularly, it is inappropriate merely for students to consolidate skills, and therefore the assessor may need to become actively involved in providing learning experiences for the student. However it is my experience that some assessors do not appear to acknowledge this aspect of their role which creates difficulties for both themselves and the student (6).

Therefore although the assessors have responsibility for particular areas of the practical component, I would suggest there is considerable overlap in that responsibility which has implications for the assessment process particularly where discrepancy exists in the interpretation of professional knowledge and the adopted paradigm of practice. This phenomenon which has further implications for the validity of the assessment procedure.

### Conclusions

I would argue that this review of the current assessment procedures demonstrates clear criticisms of the assessment process which particularly relate to the understanding of professional knowledge and interpretation of practice. This has implications for the appraisal of professional competence amongst those practitioners involved in the assessment process and raises questions about the validity of the assessment procedure. I would suggest the evidence demonstrates anomalies within both the theoretical and practical component of the course. However I do not propose to explore those



issues relating to the theoretical component in this study although it is pertinent to note that despite more than a decade having passed since the publication of the study by Fader (1976) no major changes have occurred as yet in this component of health visiting education.

For the purpose of this study, I propose to explore those issues raised in assessing the practical component of the course and I would argue that this review raises important issues which require addressing in the assessment of competence in practice. A fundamental issue concerns the understanding of professional knowledge and the interpretation of practice. This in turn raises questions about the relationship between the student and the assessor and the validity of the procedure particularly where there is a discrepancy between the interpretation of the student and the assessor or indeed between individual assessors. I would argue this is particularly pertinent when an appreciation of the concept of professional artistry is not recognised or acknowledged by the assessor in her understanding and interpretation of professional knowledge. The review not only raises questions about the skill and competence of the assessor, particularly when the literature suggests that intuitive knowing in practice plays a significant role in the process of assessment, but also about the design of the process which explicitly highlights the selection of criteria for the procedure.

Although the review raises questions about other issues pertinent to the validity of the process (what is being assessed during supervised practice, how do students relate theory and practice and how do the assessors make professional judgements of their

students' performance), I would argue that a major issue highlighted in the review relates specifically to the lack of a conceptual framework from which to inform practice and from which a theoretical framework can be developed to determine the assessment process. In addition the review demonstrates the lack of evidence in the current procedures acknowledging the concept of the "reflective practitioner". Indeed I would suggest it is these issues which have not only contributed to the growing crisis in confidence in health visiting practice but also to the gap between the reality of practice and the theory provided in the educational institutions. It is therefore these particular issues and their significance for the validity of the process of assessing competence in practice which I propose to explore within this study.

- (1) The Council for the Education and Training of Health Visitors (CETHV) was established in 1962 following the Health Visiting and Social Work (Training) Act with the remit of promoting the training of health visitors, approving the training courses set up for health visitors, making arrangements for the conduct of examinations and carrying out research into matters relevant to the training of health visitors.
- (2) The Health Visiting Joint Committee (HVJC) was set up following the Nurses, Midwives and Health Visitors Act and must be consulted by the National Boards and the United Kingdom Central Council on all matters relating to health visiting. It also maintains the responsibility by delegation from the National Boards for approval of Health Visitor Courses.
- (3) The National Boards were established in 1983 following the above Act and maintain particular responsibility for the provision and approval of courses and the conduct of examinations in nursing, midwifery and health visiting education.
- (4) This is a six day course, approved by the English National Board, and designed to enable practitioners to assess the students' competence in practice during the period of supervised practice. However the course does not demand that the competence of Assessors is assessed.
- (5) The ENB define the workload of the health visitor as the whole range of activities for which the health visitor has a professional responsibility including the client records actually held by the health visitor. The caseload refers to the population for which the health visitor has a designated responsibility. This is based either on a General Practitioner's caseload or a geographically defined catchment area.
- (6) This evidence was obtained at the briefing meeting for Assessors of Supervised Practice at the case-study College, when particular individuals stated that they did not perceive teaching as part of their role during supervised practice.

## CHAPTER 3

### Research Design and methodology

Following the review of the current methods used to assess competence in practice in health visiting I have identified five major issues which require addressing and each I would suggest is equally significant in the process of assessment. These are:

i) doubt as to the validity of the assessment procedure as identified for example by the discrepancy between student pass rates and client satisfaction,

ii) the unsatisfactory nature of the processes involved in designing the assessment procedure as seen in the difficulties encountered by practitioners in achieving a consensus of criteria for competence in practice,

iii) the difficulties created by the student-FWT relationship, particularly that of being both assessor and teacher, as reported in the literature available in health visiting and other similar professional groups,

iv) insufficient emphasis on the student's ability to reflect on and reflect in practice as evident in subsequent professional self audit,

v) the difficulties created by the inadequate information available to practitioners involved in the assessment process, as seen in the lack of literature which offers any theoretically based paradigms of assessment.

It is interesting that these issues have progressed some way from those in my original study protocol in which I had previously identified five questions for the basis of the investigation. The majority of these questions related specifically to issues about the validity and reliability of the criteria selected for

the assessment procedures. However, as my literature review progressed and I began to explore the procedures currently used to assess competence in practice I acknowledged that before I could consider the validity and reliability of specific criteria a fundamental issue required addressing: the understanding of professional knowledge and the interpretation of professional practice. Indeed I would suggest that the analysis of health visiting practice in Chapter 1 has established the conflicting paradigm of practice demonstrated by competent practitioners as a major cause for concern.

My study has therefore been designed to address an essential issue in curriculum design: the relationship between the interpretation of professional practice and the process of assessing competence in practice in health visiting education. The previous chapter has demonstrated the two distinct components of assessment in the curriculum: theory and practice. As previously stated my particular interest lies in the assessment of competence in the practice component of the course and specifically relates to the crisis in confidence in professional education. The debate in Chapter 1 has attributed this crisis to the discrepancy between the reality of the practice setting and the theoretical input in student learning, created by an epistemology of practice developed from a model of technical rationality. In order to address these issues I have identified the following objectives for my study:

- i) to identify and analyse the current methods and procedures used to assess competence in practice,
- ii) to analyse the different paradigms of health visiting practice, namely individual nondirective, collective

nondirective, individual directive and collective directive (Chapter 1: 28),

iii) to identify and analyse the interaction and relationships between the processes and individuals involved in the assessment procedures,

iv) to explore the student's perception of the discrepancies of the 'reality' of the practice setting as against the ideal in the college setting,

v) to identify and analyse the learning needs of the individuals involved in carrying out the assessment process.

vi) to develop a theoretical framework for the process of assessing competence in practice.

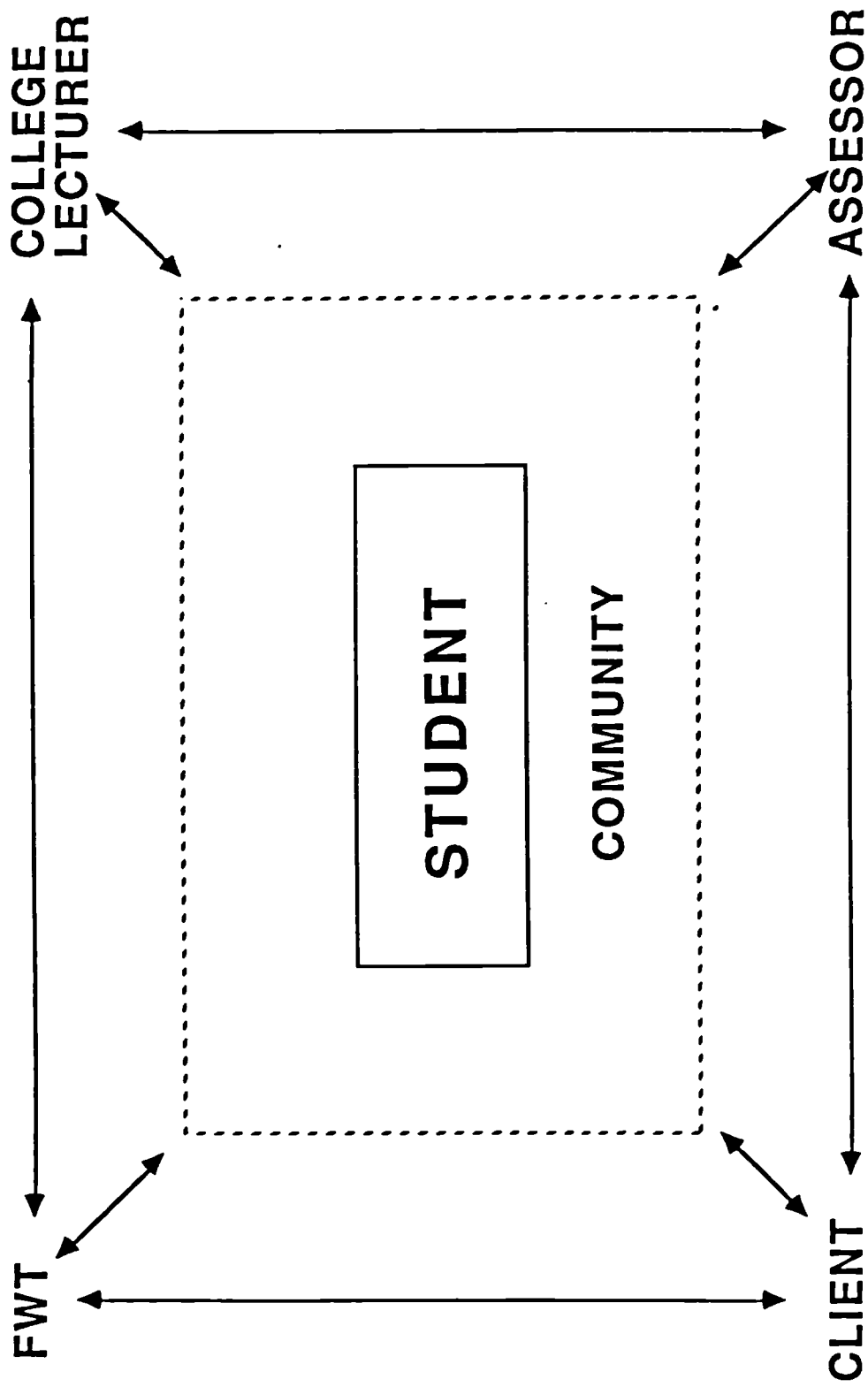
The framework for the research design in addition to meeting these objectives must also consider the processes involved in assessing competence in health visiting practice.

Although the discussion in Chapter 1 illustrates the different paradigms of practice two essential factors emerge in the process of health visiting: the client-practitioner relationship and the client as the central focus of health visiting intervention. I would argue that in order to meet the unique demands of each practice setting the practitioner is required to not only demonstrate an appreciation of the concept of professional artistry but also the ability to reflect-in-action. An appreciation of the concept of professional artistry enables the practitioner to use her intuitive knowing in practice to make sense of the practice setting and thereby make professional judgements to inform and determine strategies of promotion and prevention. However I would suggest a prerequisite in attaining

this expertise is the ability to reflect-in-action. Schon (1987) describes this ability as one in which the practitioner draws on previous practice experience to use as a framework on which to form hypotheses from similarities perceived in practice and then testing these hypotheses by experimental action in the practice setting. I would argue that it is implicit within this process that the practitioner also draws on the principles of health visiting (Chapter 1). These issues must therefore be addressed in the assessment process and reflected in the criteria selected for the assessment procedure.

Another fundamental question raised in the assessment process, is the relationship and interaction of those individuals involved in the assessment procedure. In Figure 3.1 I have tried to demonstrate the interaction of the individuals involved in the assessment of health visiting practice, thereby indicating the complexity of the procedure.

The student, who is in the centre of the process in the practice setting, is being assessed either formally or informally by individuals in four different contexts. Although each individual plays an additional role to that of the assessor, I would argue the FWT (who plays the most significant role in the assessment process) experiences the most demands on her practice. The FWT in addition to her practitioner role is entirely responsible for providing a reflective practicum. This not only involves the selection and briefing of appropriate clients but also in facilitating an epistemology of practice grounded in reflection-in-action.



THE INTERACTION OF THE INDIVIDUALS' INVOLVED  
IN THE ASSESSMENT OF PRACTICAL COMPETENCE

Figure 3.1.



The available literature relevant to the objectives identified for the investigation, was another important consideration in the design of my study. Because the literature specific to health visiting education was very limited, my literature review related predominantly to other professional groups, in particular nursing, social work and teaching. These groups were specifically selected because their categorisation as a minor profession (Glaser 1974) equates to that of health visiting. I therefore decided it was not possible to formulate a hypothesis as a grounding for my research and instead selected a multi-stage approach which included the use of a case-study. I anticipated that this approach would provide me with the opportunity of an indepth analysis of the phenomenon in one particular education setting. It would also enable me to explore and analyse the process of assessment from the different perspectives of those individuals involved in the procedure and from the data obtained generate patterns and relationships from which hypotheses could be formulated for future research. However, a case-study also allows the researcher to predict the future behaviour of participants based on relationships or events previously experienced and in this limited sense hypothesis testing can be used within the course of the case-study. (Polit, Hungler 1987). This framework therefore provided a further dimension to the design.

### Methodology

The methodology for the investigation involved a multi-stage mixed research design as illustrated in Figure 3. 2.

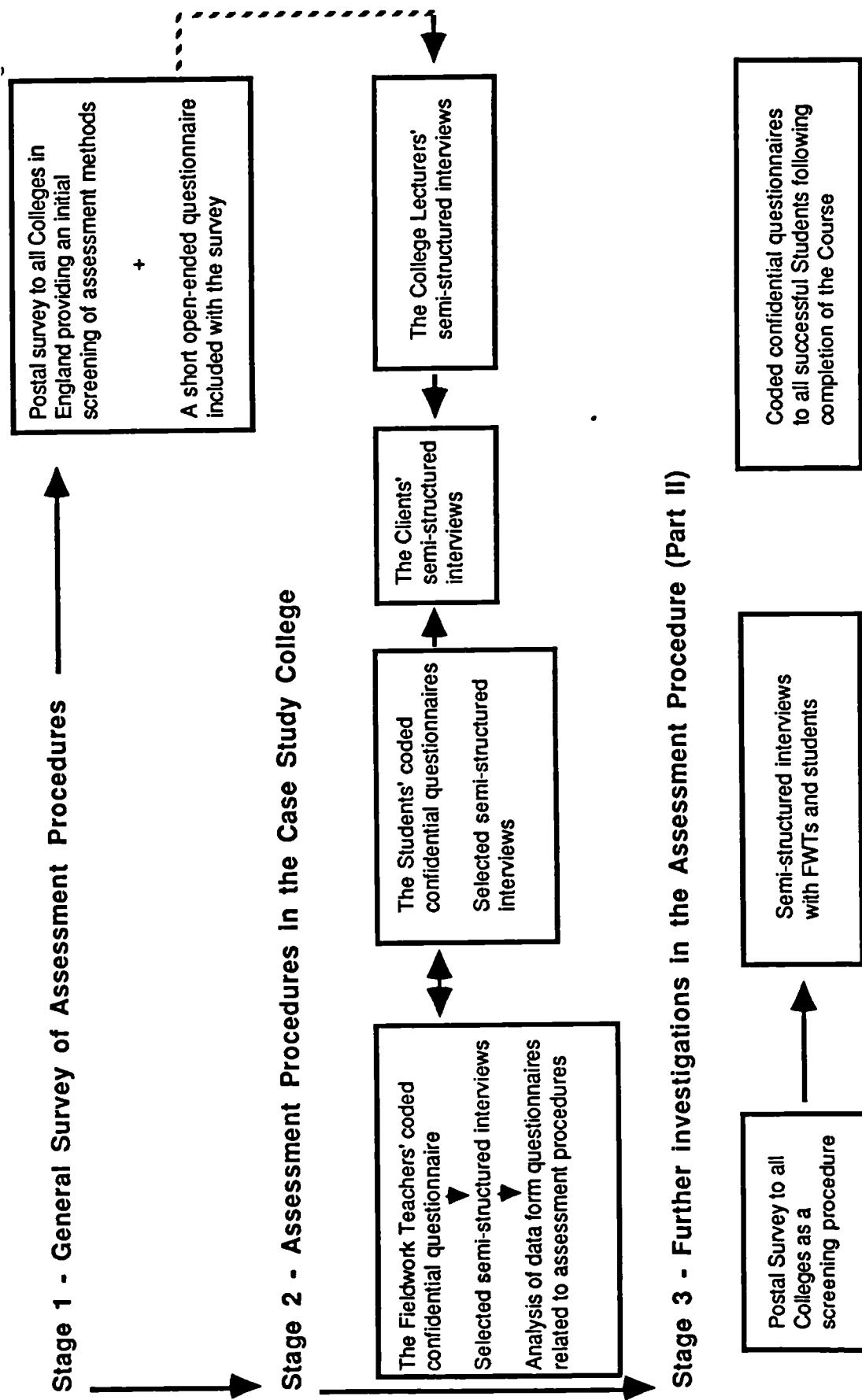


Figure 3.2.

It involved the use of surveys and a case-study. The initial stage which involved the use of a survey, was carried out not only to set the process of assessment in the case-study in the wider context of health visiting education, but also to examine the different paradigms of practice and perceptions of the nature of professional knowledge as these issues play a fundamental role in the assessment of competence in practice. Despite the case-study providing the focus for the next phase of the investigation, this was divided into two further phases to reflect the distinct stages of the assessment process: the intermediate and the final stage (Chapter 2:52). Stage 2 explores the interaction and relationship of the factors and individuals involved in assessing the students' competence in the practicum and Stage 3 explores the students' perception of the process of assessment in supervised practice. Although these two stages are considered separately in health visiting education one of the assessment procedures used in the final stage of assessing competence in practice is based on work completed in the intermediate stage and therefore provides an essential link between stage 2 and 3 of the research design.

I selected a combination of instruments in order to generate data of sufficient depth to explore the relationship between the factors and variables in the process of assessing competence in practice. These methods included the use of professional documents and questionnaires and interviews which were applied to students, FWTs, lecturers and clients. The data obtained from the questionnaires and professional documents were used to generate the focus for the interview schedules. My initial

discussions with colleagues and the literature available on assessment had demonstrated the complexity of the process and this led me to select a semi-structured interviewing technique. The structure of the interviewing procedure is particularly important if a rich source of data is to be obtained. Morton-Williams (1978) argues that two important principles must also be considered: the questions must be as open ended as possible and the questioning technique should encourage respondents to communicate their underlying attitudes, beliefs and values. This second principle was particularly important in designing the study as I needed to elicit these attributes from the students, FWTs, clients and lecturers involved in the assessment process. However I also had to acknowledge the possibility that the form of the question might prompt the informant to reveal certain attitudes rather than others in either the questionnaire or the semi-structured interview (Courtenary 1978:32).

Robertson and Boyle (1984:45) argue the need to base the interview schedule on what they describe as 'a knowledge of cultural patterns'. This is important so that the information obtained during the interview is based on ideas and concepts that are shared by both the interviewer and the participant. During my professional life I had experienced the acculturation process in health visiting (Houle 1980:57) by practising as both a health visitor and FWT. This provided the foundation for a common core of knowledge and beliefs between the interviewer and the participants. However, my position as a lecturer was more ambiguous. Although it provided a basis for sharing concepts in the interview situation, it may also have introduced a degree of

bias into the data collection. Field and Morse (1985) state that the depth of information obtained during an interview is dependent upon the interviewer's skill in achieving both a rapport and the trust of the participant. If the interviewer is seen in a position of authority this may be difficult to achieve and may limit the depth of information offered. Therefore the problem of interviewer bias must be seriously considered (Wood 1978:100), and this issue will be addressed in detail later in the chapter.

### Stage 1

#### The Postal Survey

The postal survey was designed to achieve two specific purposes: to analyse the different paradigms of practice and to screen the current methods used to assess competence in practice. Although generalisations cannot be made from the findings of a case-study I considered it important to establish the process of assessment in the case-study in the context of health visiting education. The screening of procedures would also enable an analysis of the nature of professional knowledge as perceived by educationalists which I would suggest has implications for the interpretation of professional practice. Before conducting the survey support and approval were sought from the Professional Officer for Health Visiting at the ENB. These were readily provided and considerable interest in the study was expressed. A list was also obtained of the institutions offering the health visitor course in England, and the leaders of 36 courses were circulated with an explanatory letter, a request for a copy of their current assessment procedure and a short questionnaire (Appendix D). Although I was concerned that this approach might result in a low

response rate, Brook (1978) argues that it is a false assumption that there will be a low return rate from a postal survey. In order to facilitate the maximum response a follow-up letter was sent to colleges who had not responded to the first request. In addition some colleges required a letter requesting the forwarding of their assessment procedure as their original response had included only the completed questionnaire.

The confidential questionnaire consisted of four open-ended questions. The questions were designed to identify the respondents' view about the current procedures used to assess competence in practice and to identify any specific concerns about the process of assessment. The space provided for the response was restricted to one side of A4 paper as there is evidence to suggest that too much space may inhibit respondents. Open-ended questions were used to allow the respondents to freely express their opinions. This format also provides a rich source of data from which verbatim excerpts provide a valuable insight into the tone of the replies offered by respondents. The questionnaire had been piloted with colleagues in an attempt to minimise any ambiguity in the wording and to estimate the time involved in completing the procedure. The colleagues selected to pilot the questionnaire were chosen as they were unlikely to be included in the later stages of the study. However this in fact proved untrue as one colleague was finally included in the sample of lecturers in the semi-structured interview in the case-study. As this interview took place approximately fifteen months later I did not feel any further bias was introduced into the situation. The comments from the initial pilot study were incorporated into the questionnaire and the data provided by the respondents

generated the foci for the semi-structured interviews with the FWTs and lecturers in the case-study.

## Stage 2

### The Case-Study

The college selected for the case-study is situated in Greater London and due to its location relates to approximately twelve health authorities. The college has approximately 10,000 students, the majority involved in further education. The health visitor course at the time of the empirical work in 1984 was run in the Department of Community Health and staffed by five full time lecturers in health visiting. The course was well established and had been running since 1967. It offers 42 post registration places, however in reality the course usually has an intake of approximately 34 students. The participants in the case-study included the student group, lecturers, FWTs and selected clients.

### The Fieldwork Teachers

The FWTs, who provided the student health visitors with their learning experience in the practicum during the study year 1984/85, were employed in nine different health authorities. Some had worked with the college for several years, whereas for others this was their first year. All the FWTs working with the college that year were included within the sample for the first phase of Stage 2 of the study and permission was obtained for their participation from the appropriate Director of Nursing Services (DNS) (Appendix E). All except one readily gave their agreement. In this instance the health authority gave permission

following further details of the study being submitted to their Ethical Committee. It is interesting that this was the only authority to implement this procedure before agreeing to their staff being involved in a research study. The aims of the study had been informally explained to the FWTs, whilst attending a study day in college, and no concern had been expressed about their involvement. Indeed most had expressed great interest in the project. The cohort included 28 FWTs as, in common with other courses, the student intake for the year 1984/85 had dropped, demonstrating the general reduction in recruitment to health visiting education (HVJC 1984). The questionnaire which was confidential and coded, was designed to explore the major issues in the assessment process identified earlier in the chapter. The coding of respondents was necessary so that FWTs could be identified for selection for the next phase of the study using the data obtained in the questionnaire. The questionnaire consisted of two parts: the first involved a professional biography and the second considered issues in the assessment procedure (Appendix F). A combination of closed and open ended questions was therefore employed. The questionnaire was prepiloted with a group of student FWTs who were currently undertaking the first year of the FWT course. A discussion basis was used to identify any questions which were ambiguous or inappropriate. The questionnaire was amended using the comments of the student group and then piloted with a group of 12 FWTs working with another training Institution within the region. The response rate from the pilot study was good, with the respondents completing all sections of the questionnaire. No adverse comments were received about either questionnaire design or the format of the questions. There were no questions which the



respondents considered they were unable or unwilling to answer and the questionnaire was therefore circulated to the FWT cohort. This was conducted at the end of the student health visitors' first term of fieldwork experience and followed the completion of the intermediate assessment of competence in practice. An explanatory letter (Appendix G) and stamped addressed envelope were included in the circulation of the questionnaire. The respondents were requested to complete and return the questionnaire within a three week period.

#### The semi-structured interview

Gallego (1983:43) describes a case-study as responding 'opportunisticly to whatever action is taking place' and therefore the foci for the semi-structured interview emerged from the primary analysis of the data in the questionnaire. However, in order to achieve the objectives of the study, foci were also generated from the data analysis of the initial postal survey and the literature review. In the time available for the study it was impossible to conduct an indepth interview with all the respondents and therefore a sample of FWTs was selected. I decided it was feasible to interview 50% of the respondents. Field and Morse (1985:59) argue the importance of selecting respondents who can contribute to the understanding and development of theories in the topic being researched and therefore a positive sampling method was selected (Bogden and Biklen 1982:67). This would allow me to select FWTs who had demonstrated specific characteristics and/or opinions in their responses to the questionnaire. The sample would also provide a variety of practice settings in which the process of assessment is conducted. The criteria used for selection are given below:

1. The number of years practising as an FWT -

Part II

1-2 years

3-4 years

5-6 years

more than 7 years

2. Whether the respondent had found the procedure stressful.
3. Whether the respondent had an innovative approach to health visiting practice.
4. Whether I felt the respondents would be prepared to honestly share their ideas and knowledge.

The first criterion was selected as my literature review demonstrated that the assessment process becomes easier with greater experience. This issue was also identified within the questionnaire responses. The selection therefore ranged from those who were completing the FWT course with their first student, to those who had been practising as an FWT for more than 7 years. The second criterion was selected because my reading of the literature demonstrated that the process created stress for the assessor. The responses in the questionnaire had been very divided on this issue and I considered it important to explore this issue in greater depth. The third criterion was selected to establish whether the FWTs' interpretation of professional practice had contributed to any discrepancy in the process of assessment, particularly if they had adopted a conflicting paradigm of practice to that of the student. Although the final criterion is more appropriate to an opportunistic sampling method, I decided it was important in facilitating the validity

of this stage of the empirical work, as I would argue this group of participants would be more willing to share their honest feelings and beliefs about the assessment process. Using these criteria 13 participants were selected. They were contacted initially by letter, thus providing an informed consent to their participation in the taped interview (Appendix H) (Field and Morse 1985). Although this should include an opportunity for those involved to ask further information about the interview procedure my letter did not specifically provide this facility. However this did not appear to affect the response of the participants.

Following their agreement the interview schedule was arranged, with the participants being offered a choice of venue: either in the college or at their practice base. Following an agreement with nurse managers the interviews all took place in work time, therefore providing some consistency to the interview situation. A tape recorder was used so that the information could be accurately recorded without distracting either the participant or the interviewer. It was stressed that the tapes were totally confidential. A pilot interview was conducted to establish the appropriate sequencing of the topics in the interview and to minimise the risk of bias created by the influence of earlier questions.

The final phase in this stage of the study was to link the data obtained from the questionnaire to the data obtained from the actual assessment procedure completed with the student. Both the intermediate and the final assessment procedure were used for this purpose (Appendix I). The procedures were identified by

using the same coding as the questionnaire. The comparison of this data would provide further understanding of the assessment process and facilitate the formation of inductive theory.

#### The student health visitors

Before commencing this stage of the case-study permission for the students' participation was sought from the college. Both the Head of Faculty and Head of Department agreed to the health visitor course becoming the subject of the case-study and to the student group being asked if they wished to participate in the research study. From available data the student cohort demonstrated no significant differences in social structure to other student intakes during previous academic years. (CETHV 1983). Although no generalisations can be made from the observations of this group I considered it useful to place the student cohort in the wider context of health visiting education. The original intake of students for the study year 1984/85 was 29. However one student became pregnant and decided to withdraw from the course at the end of the autumn term. Since she was not involved in the assessment procedure and would not be completing the course she was not included in the sample. One other student's fieldwork placement had broken down and therefore she had not undertaken sufficient practice by the end of the autumn term to be included in the student cohort. The questionnaire circulated to the students was confidential and coded so that the students could only be identified by the researcher. The numerical coding for the student respondent corresponded to that of their FWT, thus allowing the researcher to match student and assessor. The questionnaire was divided into three parts: the first consisted of a professional biography, the second explored

the fieldwork experience provided for the student (which I had identified within the literature as being significant in the outcome of the assessment process) and the final part explored the student's perception of the assessment process (Appendix J). The questionnaire was prepiloted with a group of students in the final stage of the health visitor course in the previous academic year at the college. Once more a general discussion was used so that any ambiguities in wording could be identified. Following minor amendments to the questionnaire, ten further students were selected for the pilot study. The response rate was good, all questions were completed and no further ambiguities were identified. The questionnaire was circulated to the student cohort at the end of the first term following the intermediate assessment procedure. The distribution occurred on the last day of term to minimise the opportunity of students conferring together about their responses. An explanatory letter and stamped addressed envelope were included in the circulation (Appendix K).

The students were requested to complete and return it by the first day of the spring term.

#### The semi-structured interview

The data obtained in the final section of the questionnaire, in conjunction with the literature review, provided the foci for the semi-structured interviews. For this phase of the study the student sample had been predetermined by the participants selected for the FWT semi-structured interview. By implementing this approach to sampling I would obtain data relating to the process of assessment from two respondents who had experienced

the same procedure but from a different perspective. I considered this particularly important as I would suggest that different perceptions of the nature of professional knowledge will influence the outcome of the assessment procedure. It is interesting, however, that this method of sampling selected participants who were representative of the total student group. Their ages ranged from 23 to 44 and previous experience included midwifery, the acute sector, community nursing and a variety of other nursing experience. Their academic qualifications ranged from one ordinary level pass in the General Certificate of Education to an honours degree. The cohort included those with a midwifery qualification as well as those who only had the required obstetric experience. There was only one student from an ethnic minority group, but once more this reflected the total group as only 3 of the 28 students were from ethnic minority groups. It is pertinent to note that had an opportunistic sampling method been employed the same participants would have been selected in several cases.

Following the selection of participants each individual was contacted by letter, thereby obtaining informed consent to the taped interview. Once consent was given the interview scheduled was arranged. Once more all the cohort were interviewed in college during the teaching day in order to achieve consistency in the interview situation. A difficulty I had to acknowledge was the possibility of interviewer bias because of my position as lecturer to the health visitor course. However, the students were assured of the confidentiality of material on the tape and the participants appeared relaxed and very willing to discuss any of the topics which were raised.

### The college lecturers

#### The semi-structured interview

The lecturing staff involved in assessing the student's competence in practice, consisted of five women members who were all qualified health visitor lecturers. The management structure ranged from principal lecturer to lecturer II. The principal lecturer had been in the department since the inception of the course and one other member had been in post for 7 years. My direct involvement, as a member of this team, had implications for this stage of the methodology. Although participants were assured of the confidentiality of the recorded material, interviewer bias has to be considered once more, particularly as the principal lecturer was my line manager and this issue is discussed in more depth later in the chapter. The foci for the semi-structured interview were generated from the data analysis of the postal questionnaire circulated to course leaders and from the data obtained from the FWTs. Informed consent was obtained from the lecturers for the taped interview. Unfortunately it was difficult to obtain interview consistency as one lecturer was on maternity leave and was therefore interviewed at home, with both her children present. It was difficult to arrange a convenient time for the interview with the principal lecturer so this was conducted some time after the others, thereby introducing a further variable into the situation. Although another colleague had only joined the lecturing staff a term before the interview took place, she had been on teaching practice within the department in the previous academic year and felt she understood the issues involved in the assessment procedure and the course structure sufficiently to be included in the interview. The

fourth member was in her second year of teaching experience. Despite these difficulties I considered the interviews provided the opportunity to obtain a rich source of data of the educationalists' perceptions of the nature of professional knowledge and the implications for assessing competence in practice.

### The clients

#### The semi-structured interview

During the initial analysis of the data from both the FWT and the student respondents the importance of the clients' role in the assessment process became very clear. This related specifically to client feedback which provided many FWTs with an informal method of assessing the student's competence in practice. Research has demonstrated that clients articulate their level of satisfaction with the health visiting intervention offered by a practitioner (Foxman 1982, Draper 1983). Although this particularly related to the practitioner's interpersonal skills I would argue that the intuitive knowing in practice which informs professional judgement is influenced by the interpersonal skills of the practitioner. In addition, in order to obtain sufficient breadth to the case-study the clients must be considered in the methodology as they play a fundamental role in the learning experience provided for the student. Therefore the final phase in this stage of the case-study was to interview clients who had been involved in student training. Before selecting clients for interview permission was sought once more from the DNS from the relevant health authorities. Most readily agreed except for one where permission was now required from their Ethical Committee as the research directly involved the participation of clients.



An opportunistic sampling method was implemented to select the clients for the semi-structured interview. Selected FWTs were requested to approach three of their clients who had been involved in student training. The FWTs were selected for their perceived competence in health visiting practice and teaching ability. Their practice environment was also considered in an attempt to provide a sample of clients from a variety of social and ethnic groups. In using these criteria I considered that the participants would have a good understanding both of health visiting practice and the students' role in relation to the FWT and the service provision. By requesting the FWT to select the clients for interview I hoped to obtain a sample of clients who were willing to articulate their opinions about their involvement in student training. Following the initial selection of participants by the FWT a letter was sent to individual clients to obtain informed consent to the taped interview. The interviews were arranged at a time and location convenient to the client. The foci for the semi-structured interview were generated from the analysis of the data from the student and FWT respondents and discussion with both colleagues and clients particularly relating to the nature of professional knowledge. The validity of the data needs careful consideration. Becker and Geer (1978) suggest that information given in a one to one situation may vary from that in a group. Although this issue is partially addressed within the interview schedule (Appendix L) it is considered in more detail later in the chapter.

### Stage 3

Chapter 2 demonstrates that the assessment of the students' competence in practice is divided into two distinct parts. The

final stage in the research design related to the second phase in the process of assessment in supervised practice. The two phases in the process are interlinked by the "health visiting study" which although a major component of the final assessment procedure is completed by the student during her time in the practicum. I would suggest that this method of assessment raises two specific issues: the extent to which the procedures are perceived as an interrelated process and the validity of the procedure as a method of assessing competence in practice. My original study protocol did not consider supervised practice as a stage within the process of assessing the student's competence in practice. The boundaries of the case-study were therefore limited by introducing this stage at a later phase and not exploring the relevant issues with the assessors of supervised practice or the clients allocated to the students during this time.

The "health visiting study", although as previously discussed is an element in the theoretical assessment procedure, reflects the health visiting intervention offered by the student to clients. I would therefore argue it must be considered additionally as a method of assessing the student's competence in practice. However, a phenomenon which must be explored in the research design is the tutorial help provided for the student in completing the study. Although the student may receive tutorial guidance from both a lecturer in health visiting and the FWT, the degree of input will vary with individuals and institutions. I would suggest this input may seriously question the validity of the health visiting study as a method of assessing competence in practice. However, in order to set the procedures used for the health visiting studies in the case-study college in the context

of health visiting education an initial survey was undertaken with all course leaders in England.

#### The postal survey

All 36 institutions in England were circulated with an explanatory letter requesting a copy of the current guidelines available to the student for completing the "health visiting study". It also included a short questionnaire using open ended questions to establish the type and extent of tutorial help offered to the student and to identify any concern generated by the use of the health visiting study as a method of assessing competence in practice (Appendix M). This letter was sent to Institutions regardless of whether they had responded to the original postal survey and indeed some Institutions responded to the request although they had not responded to the original request for a copy of their assessment procedures. In addition to providing a framework in which to set the tutorial help provided in the case-study college the data obtained provided a source of concerns relating to the validity of the health visiting study as a method of assessing competence in practice.

#### The case-study

An important focus for the semi-structured interviews with the students, FWTs and the lecturers related to the use of the "health visiting study" as an assessment procedure. Although the focal point for this topic in the interview varied depending on the participant, certain issues were important to the three groups, in particular the stress created by the preparation of the studies and the amount of tutorial help that individual students expected or received from either the FWT or the

lecturer. By using the same coding system to identify the participants as Stage 2, it was possible to compare the perceptions of student and the FWT. The influence of the interviewer on participant bias is particularly important in the student group, as some of the participants were my tutorial students and therefore commenting directly on the amount of help they had received from the interviewer.

The final phase in this stage of the study was to review the assessment process for the period of supervised practice. This was conducted by circulating a confidential questionnaire to all students who had successfully completed the course. The questionnaire was divided into three parts: the first explored the health visiting experience that had been offered to the student, the second explored the assessment procedure experienced by the student and the final part explored the student's perceptions of the oral examination occurring at the end of supervised practice. The health visiting practice experienced by the student was particularly important as this has implications for the understanding of professional knowledge and the interpretation of practice which I would suggest may influence the process of assessment. Once more the same coding system was used thereby allowing any relationships in the data to be identified and explored.

#### The validity of the research design

One of the great strengths in using a case-study approach has also been described as a 'potential weakness'. The opportunity for the researcher to gain in-depth knowledge of the thoughts, feelings and actions of individuals involved in a specific

situation may create such familiarity with the phenomenon under examination that the objectivity of the researcher may be particularly difficult (Polit, Hungler 1987). Field and Morse (1985) argue that the quality and depth of data in qualitative research is dependent on the ability of the researcher. Although I have used a combination of quantitative and qualitative methods to gather data in the research design emphasis has been placed on the use of semi-structured interviews which raises specific issues which must be addressed when considering the validity of the research design.

The validity of the research findings depend not only on the ability of the researcher to objectively report the perceptions of the participants in the study but also on the extent to which the findings represent the reality of the situation being studied. The depth of the data is dependent on the sensitivity, informed value judgement, insight and knowledge of the researcher. However these attributes in themselves can generate issues which question the validity of the study. Because of my position as a lecturer in the college used in the case-study it was particularly important that I addressed these issues in the research design by creating a disciplined framework to the study to minimise factors which may influence the validity of the study.

This was obtained by the progression in the study from the survey to the questionnaires and interviews in the case-study. The survey allowed me to set the issues generated in the case-study in the context of health visiting education. In addition it provided a method of verifying the data obtained from the

lecturers during the interviews. This was also achieved by using the actual assessment procedures completed by the FWTs. The social context in which data is gathered is also an important issue in the validity of the research design. Field and Morse (1985) argue that informants will reveal information in one context although not in another and information obtained in a one to one situation should be verified in a group situation. This was more difficult to achieve as I particularly wanted to explore issues raised in the questionnaire in depth, which I would argue, would not have been possible in a group situation. This issue was raised with the interviewees who stated that they did not consider the interview situation had affected the type of information they were prepared to reveal. However participants in the interview stage were selected from similar settings which also allowed verification of data.

The relationship between the researcher and the informants must also be considered. Although my status as a lecturer could have prevented me from obtaining certain information from the respondents I considered my relationship with that particular group of students and FWTs particularly open and trusting; an observation I would suggest is reflected in the data. However, this issue is important to acknowledge in the coding of the data.

Another important issue to consider is objectivity in reporting of the data. To overcome any bias which might have been generated by my position in the case-study college all the interviews were taped thus providing an accurate record of the material obtained from the interview. This also enables the checking of data for coding purposes. In addition the coding of the data may

influence the validity. Although only using one interviewer resolves the difficulty of researchers not agreeing on definitions derived from the data for categorisation purposes, it does require the categories to be clearly described and related to the data. It was also very important that I remained alert to the problem that my position as a lecturer could bias the findings and these issues therefore had to be considered continuously throughout the processing of the data.

It was therefore within the context of this framework that the data analysis was undertaken to explore the relationship between the interpretation of professional practice and the process of assessing competence in practice in health visiting education.

## CHAPTER 4

### Assessing competence in practice: A comparative study of current procedures

The interpretation of professional knowledge has been identified as a major influence in defining the practitioner's understanding of competence in practice (Chapter 1). This may relate specifically to concepts such as 'practice knowledge' described by England (1986) or to the 'practice phenomena' identified by Schon (1987), or indeed to the body of professional knowledge acquired by the practitioner. However, both England and Schon argue the inappropriateness of developing an epistemology of practice based on a model of technical rationality as this negates a fundamental component of competent practice: the intuition and artistry involved in making sense of the practice situation in informing and determining professional judgements. The grounding of the individual practitioner's interpretation of professional knowledge leads not only to conflicting paradigms of practice but also to discrepancies between the theory of health visiting and the reality of the practice setting. Although the introduction of the practical component in health visiting education in 1966 was designed to overcome some of these concerns, I would suggest this did not resolve the fundamental issue of the incongruity in practice between individual practitioners nor the variation in standards in practice. Indeed Wilkie (1979:29) argues that from the beginning the statutory body recognised the 'peculiarly difficult' task of not only identifying criteria for practice but trying to impose



standards of practice on staff over which they had no control. This phenomenon has continued with the statutory body never attempting to introduce a standardised procedure to assess this component of the course and the responsibility for assessing fieldwork practice has remained with the educational institution although this is not the situation with the period of supervised practice (Chapter 2).

It is my belief that these phenomena, in particular the interpretation of professional knowledge, have contributed to the current crisis in confidence in health visiting practice (Goodwin 1988). Therefore the primary aim of the comparative study was to establish the interpretation of professional knowledge and practice presented within the assessment procedures. However, it also provided the opportunity of placing the process of assessing competence in practice in the case-study college in the context of health visiting education. Because of the major restructuring of the statutory body responsible for health visiting education in 1983 (1), the study was restricted to those educational institutions which were included within the remit of the ENB, thereby minimising any inconsistencies arising from the local policies of individual Boards.

36 colleges were therefore circulated with a short questionnaire and a request for a copy of their current assessment procedure. 27 responded providing a 75% return rate which I would suggest indicates the level of interest generated by the issue of assessing competence in practice in health visiting. However, it is interesting to note that one

institution, although returning the questionnaire, refused to forward their assessment procedure for inclusion in the study as the member of staff stated she was currently involved in a research project focussing on the assessment procedure. Indeed Brook (1978:137) describes evidence which suggests that non-respondents are more likely to feel they may be judged by the response they make or feel inadequate in supplying the information requested. Unfortunately although this was a particularly pertinent observation for the study I was not able to explore this issue in more depth. In those procedures which were returned, the variation in structure was considerable; ranging from a free written report using very general guidelines indicating areas for consideration, to a very structured questionnaire using rating scales. When comparing the procedures at a macro level two were modelled on the assessment procedure provided at the time by the ENB for the period of supervised practice and two further procedures were virtually identical in structure and content. Although it would be interesting to know if there was any specific reason for this unique event, I would suggest it reflects the personal contact between the teaching staff at the two institutions.

When comparing the procedures in detail the inconsistency in both structure and content made it difficult to readily identify categories which would provide a framework for the comparison of the interpretation of professional knowledge and the adopted paradigm of practice. Therefore from material debated on competence in professional practice presented in Chapter 1 and my review of the literature on the process of assessing competence in practice described in Chapter 2, I

identified the following issues as a framework for the data analysis;

- the use of rating scales
- the use of 'knowledge, skills and attitudes'
- the use of a problem solving approach
- the use of role analysis
- the use of self assessment
- the use of client assessment.

Each of these issues, which I would argue are equally important, will be given detailed consideration. The data were acquired from the previously described postal survey and therefore the analysis is based on the assessment procedures which were in use at the time of the empirical work: the academic year 1984-85.

#### The use of rating scales

The use of rating scales raises a fundamental question in the process of assessing competence in practice: the methods used by the assessor when measuring the student's level of attainment. This question is equally pertinent regardless of the interpretation of professional knowledge and therefore provided an appropriate foundation for the comparative study. The particular issues in the use of rating scales relevant to the current study were; the range of the rating scale and the baseline established by the rater when judging the student's performance.

TABLE 4.1.

	4 point	5 point	6 point	Total	%
No. using scales	4 (23.5%)	9 (53.0%)	4 (23.5%)	17 (100%)	63.0
No. not using scales	-	-	-	10	37.0
N=				27	100.0

#### The use of rating scales in the assessment procedures

Table 4.1 demonstrates that the majority of colleges had used a rating scale in their procedure and the majority of those institutions, had implemented a five point scale. This is particularly relevant when considering the rater's ability in judging student performance as the correlation between rater error and central tendency has been well demonstrated (Klimoski and London 1974). However, the possibility of leniency in ratings must also be considered. Dobby (1981:156) in a study of the procedures used to assess student district nurses found that 6562 of the 7041 ratings analysed (representing 93% of the sample) fell into the top two ratings in the scale. I would argue this substantiates the foregoing concern, particularly as the same study by Dobby also demonstrated that external assessors unknown to the student consistently rated the students' performance on a lower scale point.

Casio and Valenzi (1977) demonstrated that despite rater training, leniency and the 'halo effect' were still evident. The conclusions offered by the authors in accounting for this phenomenon related to the fact that the police officers were seldom directly observed by the supervisors. A similar situation occurs in district nursing where the 'halo effect' has also been demonstrated (Dobby 1981) and this pattern (whereby the assessors rarely carry out direct observation on students) also occurs in health visiting.

In addition the extensive use of rating scales must raise the question of the reliability of the raters' judgement of the students' performance. Little documented evidence is available

in health visiting however the difficulty of establishing interrater reliability has been well demonstrated in other professions (Boreham 1978, Bondy 1984). Squiers (1981) in his study of psychiatric nursing demonstrated that of ten practice criteria selected by teaching staff to assess the students' competence in practice for only three were statistical significant levels of inter-reliability demonstrated, namely; attitude to patients, promptness and personal appearance. However other criteria which included attitude to visitors, practical ability, powers of observation, initiative and interest showed no correlation and indeed raters once again demonstrated the tendency to rate toward the higher ratings. In addition, I would suggest this evidence questions the baseline for rating the student's performance. Indeed I would suggest that the possibility that the assessors judge the student against that of qualified practitioners or against their own performance must be considered. Some of these issues are equally pertinent to health visiting practice and I would argue demonstrates the difficulty of implementing rating scales in measuring student performance.

Indeed, I would argue that the literature demonstrates the inappropriateness of the emphasis placed on the use of rating scales in the process of assessing competence in health visiting practice. It is also interesting that my own experience demonstrates the reluctance of assessors in being involved in rater reliability studies. The justification used to support this attitude was that it was unfair for students to be assessed by unknown assessors. However, I would suggest that their concern may also relate to the interpretation of

practice, particularly where conflicting paradigms of practice have been adopted. In addition I would suggest this issue raises another concern: the base line employed by the FWT on which to judge the students' performance. If rating scales are used the criteria for assessing the student must be clearly understood by both the student and the assessor, with the base line for the rating well established. However the criteria selected for the base line may be influenced by not only the interpretation of professional knowledge but also the paradigm of practice adopted by the practitioner. Once again demonstrating that the use of rating scales should be seriously questioned as a mechanism for assessing competence in practice.

#### The 'use of knowledge, skills and attitudes'

The recognition of the need to develop a theoretical framework for health visiting (CETHV 1977) prompted practitioners to question the appropriateness of the current syllabus for health visiting education and training. This led to the formation of the Curriculum Development Group in 1979, who were given the remit of defining and establishing "criteria for the nature of the Health Visitor Course, to produce guidelines for the development of curricula and thus formulate proposals for a revised syllabus" (CETHV 1981:1). It is interesting that although the group adopted an approach to curriculum design which was based on the use of objectives, they acknowledged that the processes experienced by the student in achieving the objectives were equally important as was "originality and creativity in the practising health visitor" (CETHV 1981:1), therefore once more highlighting the need for practitioners to acknowledge both the art and science of practice. However in

identifying the learning outcomes required by the student, the group stipulated the knowledge, skills and attitudes which would be required to underpin these outcomes, and therefore attempted to identify a body of professional knowledge specific to health visiting practice. I would suggest it is also significant that the group acknowledged that these outcomes could only be demonstrated in the practice setting. The publication of the document generated considerable interest in the concept of defining health visiting practice in terms of knowledge, skills and attitudes. An initial analysis of the procedures demonstrated that institutions had incorporated this concept into their process of assessment thereby providing an important focus for the comparative framework in identifying the categories of professional knowledge and paradigms of practice demonstrated in the assessment procedure.

#### The use of a 'skills' approach in the assessment procedure

The Curriculum group described eight major skills, which although they acknowledged were not the prerogative of one discipline or profession, were identified as major professional skills when used in the context of health visiting practice. These skills were; exploration, assessment, management, communication, teaching, advising, counselling and evaluation. By using this framework it was possible to identify institutions using a skills approach to the interpretation of professional practice.

Table 4.2. demonstrates that the majority of the respondents had employed a skills approach in the process of assessing

competence in practice. However, a proportion of the respondents had used a skills approach in combination with a prescribed paradigm of practice which I would suggest must add to the confusion on the part of the practitioners involved as to the interpretation of professional practice. In those procedures demonstrating a skills approach some institutions had introduced specific subdivisions within the major skill which made the categorisation of the skills more

TABLE 4.2.

	<u>number</u>	<u>% of sample</u>
No. using skills	14	52
No. not using skills	9	33
No. using combined approach	4	15
N	27	100

The use of a skills approach in the assessment procedures complex, and once more highlights the difficulty in identifying the interpretation of professional practice. However, particular skills were identified by the majority of the respondents and these are demonstrated in table 4.3.

It is particularly significant that record keeping was identified by 22 (81%) of the respondents, demonstrating this practice issue was also identified by those respondents not using a skills approach in the assessment process. This I would suggest indicates the emphasis placed on child protection thus reflecting the traditional paradigm of practice adopted by the majority of institutions. It is also pertinent to note



TABLE 4.3.

<u>skill</u>	<u>number</u>	<u>% of sample</u>
record writing	22	81
assessment	21	78
health education	20	74
report writing	20	74
referral to other agencies	18	67
communication	16	59
ability to plan care	14	52
observation	14	52
organisation of work	11	41
evaluation of intervention	11	41
interviewing	10	37

N = 27

The number of respondents citing a particular skill as part of  
the assessment procedure

that health education was identified as a specific skill by 20 (75%) of the cohort, however, previous evidence in Chapter 1 has illustrated that this is not given a similar priority in practice thus demonstrating the gap between the theory of health visiting and the reality of the practice setting. I would argue it is significant that skills such as evaluation and interviewing (fundamental to the concept of competence in practice if this is grounded in an epistemology of practice developed from practice issues), were not considered important by a majority.

Specific skills such as communication were broken down by some respondents into subcategories such as verbal, non-verbal and

written. However, other respondents left them in very broad categories which I would suggest allows discrepancy in interpretation between the institution, the assessor and the student. It is significant to note that during the analysis of the procedures 41 different skills were identified which I would argue demonstrates the difficulty in using a skills approach in the assessment process. Interestingly, particular skills such as 'referral to other agencies' appeared in the category described as knowledge by some institutions. This I would suggest raises the question of the possibility of achieving a consensus of whether certain activities constitute a skill or professional knowledge. Furthermore I would argue it highlights the inappropriateness of attempting to define a body of professional knowledge unique to health visiting practice (England 1986).

But nevertheless, it was possible to identify within the majority of the assessment procedures two of the major skills classified by the curriculum development group: assessment and teaching. However it is pertinent to note that evidence suggests that practitioners do not consider teaching a major component of practice. (Dunnell and Dobbs 1982). Significantly the skill of evaluation (essential in the appreciation of the concept of professional artistry) was only identified by 11 (41%) of respondents demonstrating the lack of emphasis on this particular practice issue. Indeed I would argue that this evidence highlights a fundamental issue in the relationship between the interpretation of professional practice and the assessment process: the discrepancy between the theory of health visiting and the reality of the practice

setting.

The use of an 'attitudes' approach in the assessment procedure

During the curriculum group's discussion of the attitudes appropriate for competence in practice, they specifically identified the difference between the attitudes and attributes of an individual. The group stated that the attributes considered essential to competence in practice were; empathy, flexibility, intuition, integrity and self-reliance. They stated these qualities should be considered during the selection of candidates as it was considered unlikely that an individual could acquire them at this stage in her development (CETHV 1981). It is interesting that similar attributes have been identified as a prerequisite for the specialist practitioner in health promotion (UKCC 1986). Furthermore I would argue these attributes are fundamental to an appreciation of the concept of professional artistry, particularly the use of intuitive knowing in practice. This evidence once more highlights the importance of the selection procedure for health visiting education (Chapter 2:46). The group identified 25 different factors in which the demonstration of a positive attitude was considered essential in health visiting practice. These included factors such as, the value of health, the worth and rights of individuals, the creation of a learning environment, the examination of one's own performance and the need to be methodical. Although these examples demonstrate the breadth of the definition provided by the curriculum group, this interpretation was used as a framework in the data analysis. This was undertaken by itemising the categories within each procedure and identifying those which could be

considered an assessment of the students' attitudes.

TABLE 4.4.

	<u>number</u>	<u>% of sample</u>
no. assessing attitudes	24	89
no. not assessing attitudes	3	11
N =	27	100

The number of respondents assessing attitudes within the  
assessment procedure

Table 4.4. demonstrates that the majority of procedures included a category or categories which specifically assessed the attitudes of the student. I would argue it is significant that 3 (11%) of the cohort did not consider this component of the student's professional development. However it was impossible to determine from the data whether this was because it was considered unnecessary or the procedures too complex to incorporate into an appropriate procedure. One respondent actually commented that in her opinion 'one can only attempt to measure such concrete things as technical skills in child development'. This raises the question of the interpretation of professional practice and suggests this institution has specifically attempted to develop an epistemology of practice based on a model of technical rationality. This once more raises the issue of the difference between the interpretation of professional practice perceived by educationalists and the reality of the practice setting.

However the majority of the assessment procedures included categories which assessed the attitudes of the students and these are identified in table 5. Nevertheless the lack of

consensus in identifying appropriate attitudes for competence in practice is once again demonstrated. Indeed I would argue that the identification of specific categories such as a 'good working relationship' raises the question whether these items

TABLE 4.5.

<u>attitude</u>	<u>number</u>	<u>% of sample</u>
good working relationships	24	78
adaptability	10	37
professionalism	9	33
respects confidentiality	7	26
seeks advice from colleagues	4	15
interested in health visiting	4	15

N = 27

The number of respondents who identified a particular attitude as a category in the assessment procedure

should be included within the category of skills rather than attitude. None of the procedures were more specific about the required attitude for competence in practice than is demonstrated in table 4.5. On first examining the data it seemed a wide range of attitudes could be identified. However on more careful consideration many of the attitudes originally identified were more accurately described as personality traits and therefore only actual attitudes are included in table 5. Although I would argue that the personality of the student influences their potential for an appreciation of the concept of professional artistry and indeed influences the students' teaching ability (Blackmon 1978) I would question the validity of these categories for assessing competence in practice at this stage in the student's professional development. It is

interesting that the appearance of the student was also included as a category in the procedure by almost a quarter of the respondents. Although this is not directly related to attitudes it was considered an indication of competence in practice by some institutions. I would argue it is difficult when considering the different practice settings, the different ages and backgrounds of clients and the individual health visitor to justify the inclusion of this factor as a criterion in the assessment of competence in practice.

Therefore although the majority of the procedures included criteria which specifically assess the attitudes of the students the degree of emphasis varied considerably which illustrates the prevailing confusion not only about the understanding of professional knowledge but also the interpretation of professional practice. In those procedures where there was little or no attempt to assess the attitudes of the student I would question the extent to which the interpretation of professional practice encompasses an appreciation of the concept of professional artistry and 'practice knowledge' described earlier in the chapter. Indeed I would argue that the omission of the students' attitudes from the process of assessing competence in practice, contributes to the gap between the theory of health visiting and the practice setting.

#### The use of 'knowledge' in the assessment procedure

The Curriculum development group identified 45 items of knowledge which they described as the 'underpinning body of knowledge for all learning outcomes' (CETHV 1981:21). This

includes items such as; health economics, health visiting, professionalisation, primary health care, theories relating to behaviour and the schoolhealth service. The group point out that the list was in no way intended to be exhaustive or prescriptive. However the discussion in Chapter 1 has identified the inappropriateness of identifying a body of professional knowledge as the grounding for an epistemology of practice. Indeed the breadth and diverse nature of the items of knowledge suggested by the group supports this observation. This argument is substantiated further by Schrock (1982:187) who suggests that the struggle to acquire a body of professional knowledge unique to health visiting, in order to obtain professional status, is of little benefit to the development of the profession. She suggests that health visitors should encourage clients to develop their own knowledge base thereby enabling them to make informed health choices. Sachs (1988: 48) argues that the theoretical perspective of health visiting may be 'closer to that of other educationalists than to that of nursing or social work', providing further evidence to highlight the difficulty in identifying a body of knowledge appropriate to a particular interpretation of professional practice. However, since a body of knowledge had been identified by this curriculum group as a foundation for the learning outcomes (which they stated could only be assessed in the practice setting), the identification of specific areas of knowledge provides a further focus in the framework for the data analysis.

TABLE 4.6.

specific knowledge areas identified by more than one respondent	13
specific knowledge areas identified by only one respondent	19
N =	27
<u>The number of specific areas of knowledge identified by more than one respondent</u>	

Table 4.6. demonstrates that from the 32 items of knowledge identified in the data only 13 were identified by more than one respondent. Indeed 19 items of knowledge were included by only one respondent and included items such as the 'recognition of a verrucca' a 'knowledge of health topics', 'the availability of clinics in the area' and a category simply stated as 'theoretical knowledge'. These items not only demonstrate a very traditional prescriptive and individualistic approach to the interpretation of professional knowledge but also demonstrate the confused way in which particular institutions interpret professional knowledge. In addition the classification of items of knowledge identified by more than one respondent demonstrated in table 4.7. highlights the lack of consensus of an appropriate body of knowledge for health visiting.



TABLE 4.7

<u>knowledge area</u>	<u>number</u>	<u>% of sample</u>
agencies for referral	9	33
appropriate health care advice	8	30
immunisation procedure	4	15
local health care policy	4	15
the role of the P.H.C.T.	4	15
relevant health care legislation	4	15
appropriate client groups	3	11
case conference technique	2	7
knowledge of health visiting	2	7
the work of the health visitor	2	7
the role of the health visitor	2	7
nurse management	2	7
local physical & social environment	2	7
N =	27	

Specific areas of knowledge identified by more than one  
respondent

It is significant that the most frequently cited item of knowledge is also demonstrated within the skills of health visiting, once more identifying the difficulty of using a framework of knowledge, skills and attitudes to interpret professional practice. I would also argue that these items of knowledge, neither inform professional practice nor contribute to the development of an epistemology of practice even if considered from a model of technical rationality. This evidence not only demonstrates the lack of a theoretical framework for health visiting practice but also highlights the inappropriateness of this approach in assessing the learning

outcomes classified by the Curriculum Development Group. Therefore I would argue that the analysis identifies that the majority of institutions have adopted a traditional paradigm of practice grounded in infant and maternal health. This is particularly demonstrated in the assessment of the skills of health visiting. However I would also argue that the comparative study highlights the inappropriateness of implementing a knowledge, skills and attitude approach in the interpretation of professional practice. Specific practice issues had been placed in different categories by individual institutions and the difficulty of identifying a clear definition in boundaries between the three categories has been demonstrated. Indeed this raises the question of the appropriateness of attempting to use this framework for the interpretation of professional practice.

The interpretation of professional practice also highlights the emphasis placed in the assessment process on the skills of health visiting. Although this may reflect the assessors' perception of the validity of these criteria, I would argue that it also reflects the limited interpretation of professional knowledge. The comparative study demonstrates the emphasis placed on assessing traditional skills in practice rather than the kind of knowing in practice which contributes to an appreciation of the concept of professional artistry. The data also demonstrate the discrepancy in the interpretation of professional practice between the theory of health visiting and the practice setting, particularly in relation to health education. Indeed I would suggest these issues contribute to the current crisis in health visiting practice and particularly

to the clients' interpretation of practice.

However I would suggest another factor influencing the clients' perception of health visiting relates to the way in which individual practitioners implement their own interpretation of professional practice. The use of a problem solving approach in practice therefore provided a focal point in the data analysis.

#### The use of a 'problem solving approach' in the assessment process

The use of problem solving as an effective learning strategy in professional education has been increasingly recognised (Houle 1980). Indeed its use in the process of assessing competence in practice in nursing and medicine has been well documented (Munro 1982, Boreham 1977, Crow 1980, Engel 1980). The development of models of nursing has facilitated the implementation of a problem solving approach to practice and the nursing process has become an accepted framework in implementing the models currently in use (Aggleton & Chalmers 1987). However in health visiting the concept of problem solving and the use of the nursing process have been less readily accepted (Marsden 1985). Some practitioners have objected to the principle of problem solving as it implies a problem centred approach to practice which conflicts with the fundamental philosophy of health visiting founded on the value of health and the perception of health needs. A comment frequently encountered when discussing the nursing process during the empirical stage of this study was 'it's nothing new we have always worked like that; an observation substantiated

by Clark (1982). Hendy (1983) argues that some practitioners only see the process as a record keeping exercise and this oversimplification leads to an inappropriate application. Indeed Luker and Orr (1985) argue that there is evidence to support both these statements and go on to describe their interpretation of the nursing process as a decision-making and problem solving activity which is not unique to nursing but equally pertinent to social work and education.

However a fundamental criticism of the process is that it negates two essential components of competence in practice: problem setting and the imaginative or creative component of practice. Schon (1987) argues the need for the competent practitioner to develop skills in problem setting. He describes the need for practitioners to name and frame practice issues which will in turn influence the outcome of their practice. In addition implicit in the concept of problem solving is a model of technical rationality which suggests a prescriptive predetermined course of events, thereby promoting a restricted interpretation of competence in practice. Problem solving therefore provided an additional framework for the data analysis to determine the interpretation of practice presented in the assessment procedures. The four stages of the nursing process namely assessing, planning, implementing and evaluation were used as criteria to identify this approach to professional practice.

Table 4.8 demonstrates that the majority of the institutions used some form of problem solving in the assessment process. However once more it was difficult to readily identify

TABLE 4.8

	specific skills	generalised approach	total	%
no. implementing the approach	14 (64%)	8 (36%)	22 (100%)	81.5
no not implementing			5	18.5
N =			27	100.0

The number of respondents implementing a problem solving  
approach to the assessment procedure

respondents using this approach, since a significant proportion of the procedures were based on the major skills of health visiting, and therefore assessment, planning and evaluation were included as specific categories within the procedures. Those institutions not implementing a skills approach had included problem solving within some aspect of the assessment procedure. The majority of this group related the concept to home visiting and the assessment of this component of practice was categorised using the four stages of the nursing process. Although it was not possible to identify any attempt to assess the students' ability to problem solve as a general principle in health visiting practice, one institution had identified problem solving as a general principle in their skills approach. This was demonstrated within the category of organisational skills: the ability to identify clients' needs, assess priorities, implement and modify plans and evaluate their work.

One other college identified the nursing process as the basis for a specific criterion in assessing the student's competence in practice. However it is interesting that this was seen as a descriptive procedure, rather than the student's ability to use problem solving in practice. In addition it was only seen in relation to home visiting and not a framework for practice which could be applied throughout health visiting. Therefore although the individual stages of problem solving had been identified in the assessment procedure I would suggest this does not necessarily assess the students' ability in problem solving and decision making skills since in some situations individual skills are being assessed in isolation. Indeed I would argue that the findings demonstrate the limited use of a problem solving approach to the interpretation of professional practice within the assessment procedures.

However it is significant that recently considerable interest has been generated in the concept of problem solving in practice. Lahiff (1985) argues the need for changes in nurse education to enable students to become skilled in problem solving. The Competencies described in the Statutory Instrument (1983 no. 873) for health visiting education and training specifically identify the four stages of the nursing process. Indeed some authors (Hendy 1983) argue that students have already become independent decision makers and confident in their ability by the end of the course. Although I would argue that the interest and growing acceptance of problem solving is an attempt in practice to overcome the crisis in confidence in health visiting, this approach will not resolve the situation unless practitioners and educationalists also

address the issue of problem setting and the intuitive knowing in practice which informs professional judgement.

Furthermore the data analysis demonstrates once more the gap between the educationalists and the reality of practice. Despite the move towards a problem solving approach to practice this is not reflected in the assessment procedures. Although this may demonstrate educationalists' genuine concern about this approach to practice I would argue that in reality the evidence identifies the traditional task orientated approach to practice presented in the majority of the assessment procedures. However it is interesting to note that inspite of this degree of traditionalism Clark (1984a) argues that women are still unable to describe the function of the health visitor despite being recipients of the service. Despite this evidence the use of role analysis recommended itself as another focus for the comparative study.

#### The use of role analysis

Although the material presented in Chapter 1 discusses the issues pertinent to the interpretation of professional practice much of the research undertaken into health visiting has focused on the role and function of the health visitor. Indeed Clark (1981:7) in her review of research from 1961 to 1978 particularly stated that 'it is hoped that a summary of the existing state of knowledge will be useful as a "source book" both for those who make policy decisions which affect the health visiting service and also for those who wish to undertake further research in this field'. This review considers specific aspects of the health visitor's practice

such as the pattern of home visits, work in clinics, work in schools and health education with groups and administrative work. This approach was reinforced at the time of the empirical work by the assessment procedures provided by the ENB for the period of supervised practice (Appendix A). Therefore I would suggest that the role and function provide an important focus in the analysis of the interpretation of professional practice. In order to identify those procedures using this approach to the assessment process the following definition of role was used: "the set of expectations applied to the incumbents of that particular status " (Morris 1971:397).

TABLE 4.9

	<u>number</u>	<u>%</u>
no. using role analysis	12	44
health education	20	74.0
home visiting	11	41.0
Child Health Clinics	10	37.0
referral to other agencies	5	19.0
developmental screening	2	7.0
management of office routine	2	7.0
working with PHCT	2	7.0

N = 27

The use of a role analysis approach in the assessment process  
and the frequency of citing major tasks

Table 4.9 demonstrates the number of respondents in the cohort using this approach in their assessment of competence in practice and classifies the frequency of the citation of those tasks identified in the role analysis. It is significant that health education was included by 20 (74%) of the cohort. This situation occurred as institutions using a skills approach had



specifically identified health education in practice. It is also interesting to note that in analysing the job descriptions of thirty three health authorities, group health education was the only task identified by the total sample (NSC 1980). However Dunnell and Dobbs (1982) identified that only 7% of the practitioner's time was spent in group health education. This not only demonstrates the conflicting interpretations of practice amongst practitioners but also highlights once more the discrepancy between the theory of health visiting and the reality of practice.

Once more the analysis was difficult to undertake as frequently the roles were described in relatively broad terms such as organisation, management and home visiting. However the emphasis placed on home visiting within this group is clearly demonstrated. Indeed within this category some institutions specifically identified the type of home visit which included antenatal care, the new birth visit, children under 5, the elderly, prevention of infection and contraception. Despite the evidence demonstrating a traditional individual directive paradigm of practice (Chapter 1) I would argue it is significant that the practitioners' role in the Child Health Clinic was not identified in a majority of the procedures. This I would suggest highlights the conflicting interpretation of professional practice even within this traditional paradigm and therefore raises questions about the understanding of professional knowledge.

Furthermore I would argue it is significant that a small percentage of the cohort specifically identified the

practitioners' role in developmental screening. A policy document produced by the HVA (1985a) questions the validity of educationalists engaging in the assessment of this component of students' competence in practice and indeed more recent research questions the validity of developmental screening procedures (Hall 1989). It is also significant that an equally small percentage of the cohort identified the practitioner's role as a team member, which I suggest reflects the lack of significance associated with this component of practice by those involved in the assessment procedure, and therefore has implications for the interpretation of professional practice.

I would argue that the analysis demonstrates the traditional paradigm of practice interpreted by a significant proportion of institutions which has serious implications in assessing the students' competence in practice. I would suggest this interpretation not only limits the assessment of competence to prescribed tasks but also fails to address the concept of professional artistry (fundamental to the competent practitioner) thereby contributing to the current crisis in confidence in health visiting practice. It also raises the question of the discrepancy between the interpretation of practice of those involved in student education and training. The introduction of strictly prescribed practice roles within the procedure has implications for both the FWT and the client; particularly where client groups are specified. Anecdotal evidence suggests that some FWTs use specific families repeatedly for student training because of the learning experience provided for the student. This particularly relates to the elderly and disabled which must raise the question of

the ethics of this practice. Consistent evidence from the inquiries into child deaths illustrates the need to identify the students' ability to organise and manage a caseload (Sharman 1983) and I would argue these practice issues are not explicitly within an assessment process grounded in role analysis. In addition this approach particularly negates the student's ability in self assessment which is essential if an epistemology of practice grounded in reflection-in-action is to determine the interpretation of professional practice. The use of self assessment in the procedures therefore provided another focus in the data analysis.

#### The use of self assessment

Houle (1980:258) describes the rapid growth of programmes in the art of self assessment that has occurred in the United States since the 1960s. However it is significant that a major criticism of these programmes is that the emphasis remains with a defined knowledge base rather than addressing the wider issues which determine competence in practice. Furthermore he suggests that the introduction of client management problems is a relatively recent innovation in the programme. Schon (1987) takes this argument a stage further and suggests that the relationship between competence in practice and professional knowledge should be turned upside down; by asking what can be learnt from an analysis of the concept of professional artistry and how this relates to an epistemology of practice grounded in a model of technical rationality. It is also pertinent to note that Houle (1980) describes many of the practitioners who enroll on these programmes as innovative and motivated;

professional qualities which I would suggest are essential to an understanding and an appreciation of the concept of professional artistry. Indeed I would argue that self assessment is essential to the continued professional development of the practitioner.

In health visiting self assessment is particularly important as currently practitioners frequently work in professionally isolated situations, with little opportunity available for peer audit. The use of self assessment was therefore used as a method of identifying the interpretation of professional practice in the comparative study.

TABLE 4.10

	specific skill	general skills	total	%
no. using self assessment	1 (7%)	13 (93%)	14 (100%)	52
no. not using self assessment			13	48
N =			27	100

The use of self-assessment in the assessment procedure

Table 4.10 demonstrates that only half of the respondents had included self assessment within the assessment process and of these one had specifically identified it as a skill in health education. The remaining institutions included self assessment within a variety of categories. In some instances this was in the skill of evaluation and another included it in that of management. However where a role analysis approach had been

implemented it was identified in the category of home visiting, which I would suggest once more illustrates the task orientated traditional interpretation of professional practice demonstrated in a significant proportion of the assessment procedures. Although other institutions had included self assessment within the personal qualities of the student (which in some cases had been subdivided into self awareness and professional attributes) I would argue it is significant that the students' ability to undertake self assessment is not specifically identified as a separate category within the interpretation of professional practice. This finding therefore raises the question of the extent to which the concept of professional artistry is recognised in the paradigms of practice presented in the assessment procedures. However it is perhaps significant that I did not include a specific question on the concept of self assessment in the original postal survey thus indicating the change in emphasis on this practice issue during the research process.

Another issue which was not included within the original postal survey was that of client assessment which is particularly pertinent considering the degree of client dissatisfaction with the service. I would suggest this reflects the attitude towards the role of consumer participation in the assessment process. However, if educationalists are to address the current crisis in confidence in professional practice I would argue the issue of assessment by the client must be considered. The use of client assessment therefore formed the final focus in the comparative study.

### The use of client assessment

Anecdotal evidence suggests that an argument offered by FWTs for not using clients in assessing the students' competence in practice, is that many clients do not understand the role of the health visitor and therefore their assessment of the students' performance would be inappropriate. Although the findings of Clark (1984) support this argument, I would suggest it is pertinent that research carried out into consumer perceptions of health visiting demonstrates that clients can articulate their dissatisfaction with the service. In a study of 85 primiparous mothers Foxman et al (1982) demonstrated that the majority of women had found health visiting intervention helpful. However as in similar studies (Orr 1980, Field et al 1982) approximately 25% of the women were dissatisfied with the service they had received. The main criticism identified was the difficulty experienced by practitioners in effective and appropriate communication (Foxman et al 1982). This I would argue directly influences the practitioner's ability to manage the unique practice setting and therefore highlights the essential role of client participation in the assessment process.

It was apparent from the survey reported in this chapter that none of the assessment procedures had included the use of client assessment, and undoubtedly raises questions about how this essential component of competence in practice is assessed. However it is pertinent to note that research has demonstrated that FWTs use informal feedback from clients (Dean 1981). This I would argue illustrates the conflict experienced by FWTs in the use of clients in the assessment process. Although this may

reflect their dual responsibility as a practitioner and teacher, I would argue this evidence illustrates once more the discrepancy in theory and practice amongst individual assessors involved in the assessment process. Indeed I would suggest it also raises questions about the validity of the procedures currently employed in assessing the students' competence in practice.

### Conclusions

The comparative study of the assessment procedures employed by the educational institutions raises issues which are fundamental to the process of assessing competence in practice. The interpretation of professional knowledge (which has implications for the interpretation of professional practice), the concept of professional artistry and the discrepancy between theory and the reality of the practice setting are particularly pertinent. The interpretation of professional practice highlights a traditional individual directive paradigm of practice with an emphasis on record keeping. This I would argue reflects the current professional preoccupation with child protection rather than the fundamental philosophy of health promotion. The interpretation of professional knowledge demonstrated the difficulty of defining a body of knowledge specific to health visiting, thereby supporting the arguments proposed by England (1986) and Schon (1987). In addition, the comparative study demonstrates the lack of a theoretical framework to the assessment process and equally significantly a conceptual framework for professional practice. This I would suggest results in practice being described in the context of tasks in relation to specific client groups. This approach

negates the significance of the affective learning domain which has particular relevance to the concept of professional artistry.

Although the concept of professional artistry has been increasingly recognised as an essential component of competence in practice, it is interesting that the concept could not be readily identified in the procedures in the comparative study. Indeed I would argue it is significant that a small percentage of the assessment procedures did not actually consider those attitudes and attributes considered essential in the development of an appreciation of the concept of professional artistry. It is interesting that skills such as self assessment, interviewing and evaluation could not be identified in many of the assessment procedures. Indeed assessment techniques which I would argue are particularly pertinent in assessing an appreciation of the concept of professional artistry, such as client assessment, were not addressed by any of the procedures. Those assessment procedures incorporating a problem solving approach to practice also raise questions as to the extent to which the concept of professional artistry has been considered within the assessment process. Schon (1987) argues that the use of a problem solving approach encourages practitioners to practice in a rigid prescriptive manner which ignores those problems of real world practice which do not present themselves in well formed structures. The comparative study also demonstrated the discrepancy between theory and the reality of the practice setting. An example of this phenomenon is demonstrated in the practice issue of health education. Considerable emphasis is placed on this issue by those involved



in designing the assessment procedure, however evidence suggests that this is not reflected in practice (Dunnell & Dobbs 1982).

Therefore I would argue that the comparative study demonstrates the difficulty of achieving an interpretation of professional practice which is common to educationalists, practitioners and clients and indeed to individuals within these groups. I would suggest this can be attributed to the lack of a conceptual framework for practice and in particular to the lack of a theoretical framework to the process of assessment. Indeed, I would argue that this evidence must raise doubt as to the validity of the current procedures used to assess competence in practice and in addition highlights the need to consider the interpretation of professional practice of those individuals involved in the assessment process, particularly their understanding of professional knowledge.

- (1) Following the Nurses, Midwives and Health Visitors Act 1979 the CETHV was dissolved and the functions of the CETHV were absorbed by the National Boards.

## CHAPTER 5

### The interpretation of professional knowledge: the implications for assessing competence in practice

The difficulty in establishing a definition of competence in practice which is equally acceptable to practitioners, educationalists and indeed consumers of the service emerged as a major finding in the comparative study of the assessment procedures described in Chapter 4. I would suggest this raises two particular issues which require addressing: the interpretation of professional knowledge (and indeed professional practice) and the validity of the procedure employed in assessing competence in practice. These issues will be addressed sequentially from the different perspectives of those involved in the process of assessment. Since those in education are currently responsible for implementing the procedures used to assess competence in practice at the intermediate stage of the examination I will begin by exploring their interpretation of professional knowledge and their perception of the assessment procedure.

The process of assessment reflects the teaching team's understanding of professional knowledge and the extent to which professional requirements, such as those identified in the Statutory Instrument (1983: No. 873) have been incorporated into the interpretation of practice presented in the procedure. In addition this interpretation of practice will reflect the extent to which an appreciation of the concept of professional artistry is considered a component of professional knowledge and furthermore whether the concept of reflection-in-action provides a

grounding for the epistemology of practice. The validity of the assessment process will be influenced by the design of the actual procedure as well as the assessor responsible for implementing the process. The influence of the assessor may be demonstrated in the provision of learning experiences, in performing the procedure or indeed in the concept of role modelling which is discussed in detail in Chapter 6. These issues therefore provided the framework for the analysis of the postal survey completed by lecturers in health visiting and a focal point in the semi-structured interviews with the lecturers in the case-study. A particularly useful source of data was provided by the open-ended question asking respondents to identify any specific areas of concern in the assessment of fieldwork practice.

#### The lecturers' perception of the nature of professional knowledge

One important theme to emerge from the question identified above was the perceived difficulty experienced by practitioners in defining health visiting practice. Concern was expressed at the limited perception of practice presented in the learning experience offered to the students. When this issue was pursued in the semi-structured interviews similar findings were identified. The four participants expressed their concern about the learning experience provided for the student. Significantly each lecturer identified quite different factors namely; the setting in which the fieldwork teachers were based, carrying out specific developmental screening procedures, coping with emotional factors such as anger, unhappiness and bereavement and experience of working with groups in health education. One lecturer commented "...I still think their teaching practice experience can be a bit of a hassle and a last minute issue, fitted in at a time when

they're absolutely up to their eyes with assignments and revision...". This I would argue supports the evidence presented by Dunnell and Dobbs (1982) demonstrating health education as a minor component of practice, rather than a central core. A common factor was the students' limited experience of working with clients of different age groups: the elderly and the middle aged were specifically identified. This was illustrated with the comment "...I think it's a pity that they don't see the whole age range - but it's not awfully easy to actually dig out an elderly...and also I hate the ethics of fishing out an elderly who is visited intensely for nine months and then dropped". In addition I would suggest this demonstrates a traditional paradigm of practice. It is interesting that although the lecturers acknowledged the need for students to experience client groups of different ages they continued to describe practice in terms of task analysis and client groups, rather than the principles of health visiting which I would argue demonstrates the lack of a conceptual framework for practice. I would suggest it is also significant this cohort identified different practice issues within a traditional paradigm of practice, demonstrating the different interpretations of professional knowledge even within one paradigm.

The data obtained from the survey did however, demonstrate the lecturers' perception of the significance of the interpersonal skills of the student in the interpretation of practice. Although acknowledged as an essential component of practice the difficulty in assessing communication skills was identified by two lecturers in the case study. One related this to the indirect assessment of the student's practice undertaken by the FWT stating "...I think

that's because the fieldwork teacher is not always present at the in-depth business that the student does in the home and that is the major part of their work...'. The other related it to the level of practice demonstrated by the FWT saying, "...we know there are FWTs that we use, that we are forced to use, who don't get on well with their clients...how on earth can they assess when their own communication skills are poor...it takes a very big person not to be jealous of someone who's obviously going to do the job as well as you if not better'.

In addition the influence of the attitudes of the student was also identified. This finding was associated with the issue of the criteria on which to judge the student's practice, and particularly related to the grey area such as "the student whose attitude towards clients was questionable". The students' motivation and interest in health visiting was identified as a concern by one lecturer. Indeed she considered it the FWTs' responsibility to motivate the student. I would suggest these data demonstrate that although a traditional paradigm of practice is described, factors influencing the students' ability in understanding and appreciating the concept of professional artistry are encompassed within that interpretation of practice. However I would argue that the significance of this component of professional practice is not explicitly recognised nor understood by many of the lecturers. This is illustrated by one respondent who commented, "there are times when we all feel uneasy about a student's practical competence but are unable to define the problem sufficiently well to legitimately fail the student'.

The concept of reflection-in-action although more complex, could

not be identified as a specific category in the data. However, the data generated from the question relating to concerns about the assessment process demonstrated an indirect reference to this concept in practice. This was highlighted by the cohort's description of the inadequacy of the FWTs in recording their observations of the students' performance, particularly in writing. Although this may indicate concern about the level of competence in committing judgements to paper, I would also argue that it demonstrates an acknowledgement by the lecturers, of the need for practitioners to reflect on practice; an essential stage in the process of reflection-in-action. It is also significant that one lecturer in the case-study commented ...perhaps we're doing it the wrong way round, perhaps we should be looking at caseload profiles and then hoiking out assessment schemes out of that...'. I would suggest these observations acknowledge the need to develop an epistemology of practice developed from the reality of the practice setting (Schon 1987).

Therefore I would argue that the data not only demonstrate an emphasis on a traditional paradigm of practice, but also that although the significance of factors influencing the concept of professional artistry is acknowledged, an understanding and appreciation of this concept is not perceived as a fundamental component of professional practice. Indeed the findings indicate a restricted interpretation of professional practice which has implications for assessing competence in practice, and in particular for the design of the assessment process. It is these factors which contribute to the disparity between the reality of practice and the theoretical component of the course.

Another essential issue in the process of assessing competence in practice is the validity of the assessment procedure. Although this issue is related to the interpretation of professional practice I would suggest that there are additional factors which require addressing, in particular the significance of role modelling and the intuitive knowing in practice demonstrated by the FWT.

#### The Lecturers' perception of the validity of the assessment procedure

Although the data from the questionnaire did not explicitly illuminate individual lecturers' perception of the nature of professional knowledge, it is possible to establish specific perceptions of the validity of the procedure in assessing the students' competence in practice. Only 9 (36%) of the respondents described the procedures as adequate and I would argue it is significant that these respondents expressed serious reservations. One stated 'at a somewhat superficial unscientific level I am reasonably satisfied', another commented 'the present methods are adequate given the complex nature of assessment'. This I would suggest illustrates the conflict experienced by those involved in designing the procedures. 8 (32%) respondents did not comment on the degree of adequacy but made general statements such as: 'we need a working party on this' and 'we need a variety of approaches to illuminate the complexities and define what needs to be measured'. Although some of these comments highlight the debate amongst lecturers in health visiting about the nature of professional knowledge, they also demonstrate the general concern experienced by lecturers in the ability of the FWT to define competence in practice, an issue which is discussed later in the

chapter.

The lecturers' perception of the validity of the assessment procedure was pursued further by exploring their plans to revise the assessment procedures. In the data from the 15 (60%) respondents who planned to revise their procedures three main themes could be identified: the need to constantly monitor the assessment procedures, the increased responsibility of the FWT, and the need to develop student self-assessment. The need to constantly monitor the procedure was specifically related to the changes in health visiting practice. Those who described the increased responsibility of the FWT related this to the introduction of the revised regulations for health visiting education in 1982 (CETHV 1982). These required the report submitted by the tutor at the intermediate examination to incorporate the FWT's assessment of the students' performance in practice. These respondents also related the need to reconsider the criteria used in the procedure and the timing of the submission of the assessment to the examination board, to this increased responsibility. However none of the respondents identified the criteria on which this revision would be based. The final theme related to the introduction of student self-assessment and this was described as an important development within the procedure. This issue was explored further in the case-study. Each of the lecturers identified self-assessment as an important criterion and related it specifically to the students' professional development. This is illustrated by the comment '...yes because that to me is what health visiting is about - personal growth and development...'. This feeling was reinforced by another comment '...if a student can look back and



see how they've developed it is an important part of their maturation as a health visitor...'. One lecturer described the process already occurring informally since some FWTs requested that the student complete the assessment procedure prior to their formal meeting in order to provide a basis for discussion. However the lecturers also identified the difficulties experienced by students in undertaking self-assessment. This related to personality factors such as self-consciousness, the generation of anxiety and the lack of awareness of the need for certain skills in health visiting practice. One lecturer considered it difficult for students to have an appropriate level of self-awareness. Another lecturer considered that some students were already competent in this skill and gave the illustration of one student's description of her early health visiting practice saying '...she said "yes I realise now I look back, I went in there organising her life as a midwife, I look back now and cringe when I think about what I did on that visit..."'.

Of the 10 (40%) respondents in the survey who had no plans to revise their assessment procedures the major theme related to recently having changed the procedure. This was illustrated by the comment 'having recently revised the assessment forms it is unlikely that any radical change will be proposed, however discussions at the end of the academic year have been planned for all involved, therefore minor alterations may be made'. Another described their procedure as having been changed from a 'complicated format to a more simple method based on the forms for supervised practice'. (1) Other lecturers related the lack of plans for revision to the fact that FWTs had been involved in designing the assessment procedure. I would suggest that it is

significant that although the lecturers related the lack of need for revision to the recent introduction of the procedures, they did not identify any criteria on which the evaluation of the procedure was based. Indeed the predominant method of evaluation was described by the comment 'the subject is on an agenda of our fieldwork teacher meetings each year'.

Although it is not possible to identify any correlation between the lecturers' perception of the validity of the assessment procedure and plans to revise procedures I would argue it is significant that there was less perceived need for change where the FWTs had been involved in designing the procedure.

The extent to which external factors influenced the validity of the assessment procedure was explored with the lecturers in the case-study. The lecturers were asked if they considered the appearance of students influenced the assessment process. This was interpreted as the student's mode of dress and each identified this issue in influencing the assessment procedure. This related specifically to the concept of appropriate dress for client groups. However, one lecturer demonstrated her own ambivalence about the effects of dress on the assessor's perception of the student's performance saying '...I feel very divided about that - I think on balance I don't feel we should because I think that's an invasion on their rights as a person to project themselves in the way they want - and certainly in places where you get all the middle class trendy mums in jeans and dungarees it actually adds to the communication if you turn up in trousers - looking a bit like them in a way - I think it's quite important to the client not to the assessor...'.

Dress was also related to the professional credibility of the health visitor with the comment '...if they're trying to get across a health education message or something and the person isn't going to be receptive because of their appearance then it is part of their competence as a health visitor - ...'. However, I would argue that it is also possible to identify the prejudice demonstrated by some lecturers in relation to the students' dress. This was illustrated by the comment '...I feel that the profession does not need people who look like jam in old wellies and I don't think the wrinkled stocking and lace-up shoe does the professional image any good - it shouldn't matter but it does...". Dress could also be identified in influencing the lecturers' perception of the professional status of health visiting with the comment '...some health visiting clients might like you shuffling around in jeans where some others might like you to be neatly attired, to look the position...'. I would suggest these findings illustrate the additional dimension of the interpretation of competence in practice and the possibility of the prejudice of the assessor entering the arena which has implications for the assessment process in practice.

It is significant however that when more innovative approaches of student assessment were introduced as a method of exploring the adequacy of the assessment procedure, the lecturers in the case-study were reluctant to implement these methods. This particularly related to the issue of involving clients in the process. Only two of the lecturers were enthusiastic about this concept and this related to the honesty of the appraisal and the amount of information that would be available. This was illustrated by the comment '...I think very often perhaps clients will be the best judge of students' performance particularly when

they're visiting alone. Very often they may give a more honest appraisal...'. However the two who expressed doubts about client involvement related this to the clients' lack of understanding of health visiting practice and the inappropriateness of only using client feedback. This was illustrated by the comment '...I'm all for consumer involvement but I think there are other ways of gauging students interaction with clients...reference to the students, ringing up for her at the clinic or coming to her - informal feedback...'. I would suggest that it is significant that this lecturer also questioned whether it was wise to acknowledge the student status of the student to the client. I would suggest this approach not only has serious implications for the learning experience provided for the student, but also the health visiting intervention offered to the client. Indeed I would argue that it is significant that the issue of client assessment was not identified in the survey data and only acknowledged with reluctance in the case-study. Furthermore it demonstrates the apprehension experienced by some lecturers in the involvement of consumers in the process of student assessment despite this being one of the most valid methods of assessing the competence of the student's understanding and appreciation of the concept of professional artistry.

Therefore I would argue that the data demonstrate the concern expressed by lecturers about the validity of the current procedures in assessing competence in practice. This relates not only to the interpretation of professional practice and the implications for designing the assessment procedure but also to those factors which may influence the assessors perception of competence in practice. I would argue it is significant that a

major theme to emerge from the evidence supporting the revision of procedures, relates to changes in health visiting practice. This suggests that professional knowledge is interpreted as task orientated rather than based upon a conceptual model of health visiting. The latter would provide consistency in the grounding of practice, despite changes in client groups or change in practice priorities. It is pertinent that student self-assessment was recognised as an essential element of professional development and thus should be reflected within the assessment procedure. However, I would argue that although the lecturers' interpretation of professional knowledge acknowledges the factors influencing the students' ability to understand and appreciate the concept of professional artistry they do not recognise this concept as a fundamental component of competence in practice. The limited involvement of FWTs in the preparation of the procedure also has implications for the assessment process particularly where their interpretation of professional practice differs from that of the lecturers. Furthermore the data demonstrate that the respondents perceived that the FWTs played a major role in influencing the validity of the assessment procedures.

#### The lecturers' perception of the influence of the FWT on the validity of the assessment procedure

A recurrent theme in the data obtained from the postal survey identified the lecturers' concern about the competence of the FWT in the process of student assessment and in particular the FWTs' influence on the validity of the assessment procedure. This is illustrated by the comment 'this is a difficult area - we are dependent upon the fieldwork teacher's assessment which is influenced by their (fieldwork teacher's) ability to clearly

define both criteria for visiting and acceptable levels of practice, some fieldwork teachers are good others are not'. This issue was also demonstrated when the lecturers were asked to select particular areas of concern in the assessment procedure. Two issues identified related specifically to the FWT: the need to improve the FWTs' skills in assessment and their ability to be objective in carrying out the procedure. A similar finding emerged from the case-study with each lecturer expressing their concern about the current assessment procedures. This related to the subjectivity of the process, lack of honesty in the assessors, lack of consensus between the FWTs' verbal and written comments on the student's performance, lack of contact between the FWT and the lecturer and the outcome as a reflection of the FWTs' teaching skills. I identified two specific issues which I would suggest influence the validity of the assessment procedure: the FWT's expertise in the process of assessment (in particular their ability to remain objective during the procedure) and the FWTs' interpretation of professional practice. Although the available data made it impossible to identify the lecturers' perception of the FWTs' interpretation of professional practice, the FWTs' perception of this issue is explored in Chapter 6. The FWTs' expertise in the assessment process therefore provided the focus for the analysis of the lecturers' perception of the FWTs' influence on the validity of the assessment procedure.

The process of student assessment has been described as being the most complex and least popular element of fieldwork teaching (Dean 1981, Chapman 1979). Indeed the lecturers' perceptions of the FWTs' role in assessment support this finding. Only 10 (40%) of the sample described the FWT as competent in the assessment

process and within this group concern was expressed about the confidence of the FWT in undertaking the procedure. This is illustrated by the comment 'I think they feel competent in assessing some skills, e.g., performing developmental surveillance, group teaching but have difficulty in assessing interpersonal skills, many also have difficulty in discussing areas of weakness even when they do make an accurate assessment'. A dominant theme in the data was the observation by lecturing staff that the level of competence in assessment had increased in those FWTs who had experienced the revised fieldwork teacher training introduced in 1977. When this issue was explored in the case-study all the lecturers perceived a difference in those FWTs who had recently trained. This was linked to the opportunity provided in the supervisory year for the FWTs to practice their skills with the guidance from members of the lecturing team. Two lecturers specifically identified a change in philosophy amongst FWTs; a philosophy which supported the teaching and sharing of ideas rather than the student learning a model of practice which encompassed a specific body of knowledge. The lecturers also identified a change in the expectations of the FWT as the revised course placed a much greater emphasis on the skills of teaching and assessing instead of updating professional practice. Indeed the difference in expectations was related specifically to the assessment procedure with the comment '...I do think there's a place for fieldwork teaching refresher courses bringing them up to date because I don't think old fieldwork teachers understand the whole process of assessment because they just had to write a line...'. A difference in attitude to the student was also described and is illustrated by the comment '...the fieldwork teachers that are trained recently are very much more on the ball

and they do seem to be much more enthusiastic and much more conscientious about the student and making sure the student is carefully guided through the year - not to say some of other fieldwork teachers aren't excellent but I do feel there's a gap there...'. .

The lecturers' perception of the FWTs' training in the process of assessment was explored further by discussing the use made of the rating scales provided in the assessment procedure. The lecturers were divided in their opinions about the use of rating scales as an assessment technique and indeed one person expressed totally negative feelings. However all identified concerns about the methods used to rate students' performance which were; the base line implemented for judging the student's performance, the variation in the number of times the student had practised a skill before the formal assessment, the interpretation of the skill requiring assessment and the actual methods used to make the rating. This particular point was illustrated with the comment '...but I think what worries me more about the criteria is how much they're directly observing the students - how much they're visiting with the students - that sort of thing - or how much they're assessing the students purely on verbal feedback without actually looking at their interaction skills on a first hand basis...'. .

The 7 (28%) respondents in the survey who described FWTs as lacking competence in student assessment identified the following factors supporting their concern; the lack of objectivity, lack of sufficient details on the student's performance, different paradigms of practice and a reflection of the FWT's teaching



skills. It is interesting that the personality of the FWT was identified as a significant factor in the validity of the procedure and was considered more influential than the degree of expertise which had been obtained. A dominant theme identified FWTs as being both confident and competent while assessing the obviously competent student. However the issue of the borderline student highlighted the lecturers' concern about the level of competence demonstrated by the FWT. This is illustrated by the comment '...very confident until they get a student health visitor with problems - frequently have difficulty in identifying the problem and verbalising it'. Although a similar pattern was presented in the case-study, each lecturer identified a different area of concern in the assessment of the borderline student. One lecturer specifically articulated the difference between a student considered borderline in practice rather than the theoretical component of the course saying '...I think you're on safer ground than you are with college because if the fieldwork teacher thinks she's borderline you've got good grounds not to pass the assessment...'. It is significant however that this lecturer considered it appropriate to involve the college in the assessment procedure where a student's performance was assessed as borderline which I would suggest demonstrates differing perceptions of the competence of the FWT. I would argue that the issue of the borderline student creates a dilemma in the assessment process since it requires the FWT to critically analyse the students' practice in order to identify elements of professional practice which are unsatisfactory or omitted in the student's performance. The concept of the obviously competent student therefore creates an inherent problem in the process of assessment since it negates the need for either practitioners or lecturers to reflect on those

practice issues which must be demonstrated by the competent practitioner.

The lecturers' perception of the FWTs' ability in committing their judgement of the students' performance to paper was another issue to emerge from the data. The concerns identified in relation to the FWTs' written assessment were; insufficient detail on the student's performance, overt contradiction between the verbal and written report of the student's performance and loyalty to the student. When these issues were explored further in the case-study the dominant theme related to the difficulty experienced by FWTs in making written comments which criticised the student's performance. One lecturer demonstrated her feelings by saying '...without a doubt - there's safety in saying it - once you have put it down on paper you may have to defend it...'. Another lecturer described similar feelings saying '...if you put too much in writing you can get pulled up on that and I think that's what fieldwork teachers feel, whereas if you make very broad outlines or broad statements nobody can ever turn round and criticise what you've put - that sounds like cowardice but that's the way I feel about it and I think that's the way fieldwork teachers feel...'. Another described her perception of the difficulty experienced by FWTs saying '...I think they do when pushed - I think it's extremely difficult for a fieldwork teacher to say she's unhappy with the student's performance sufficiently to either get the student seen in college or the student removed - it happened to me and it was horrible - it's actually very difficult to say this girl you don't feel is right for the job or the job's right for her - and what you're basing on - is just a gut feeling...'. This highlights the significance of intuition in

the assessment process and this concept is discussed in more detail later in the chapter.

When asked if they had experienced any difficulty in obtaining enough information about the students' performance the lecturers were divided in their opinion. Two stated that this was not a problem although neither was specific in their response. One said '...you can often tell how well the student is doing by the way which the fieldwork teacher speaks about the student - you can usually tell when the fieldwork teacher thinks her student is doing quite well...'. The other was concerned about assessing the student once she '...cut the cord from the fieldwork teacher and visits alone...'. The two lecturers who described difficulties in obtaining sufficient information related this to the FWTs' feelings about the students' performance. One stated that the FWT could be very defensive when things were not going well and the other related it to the FWT not having made up her own mind about the student which created '...a degree of cover-up...'. Although the data demonstrate the lecturer's perception of the difficulties experienced by FWTs, I would argue that this phenomenon is augmented by the current training offered to FWTs. Unless the nature of professional knowledge has been explored in depth prior to attending the course there is limited time available to facilitate this process and develop the ability to make professional judgements and communicate these appropriately to the student.

A particular concern expressed in the survey data related to lecturers' perceptions of the ability of the FWT to remain objective during the assessment procedure. This I would suggest

can be partly attributed to the concept of role modelling. The influence of the FWT as a role model is demonstrated throughout the data and can be identified in the responses to all questions except that relating to plans to revise the assessment procedure. One lecturer described the level of competence in the student as reflecting the level of practice of both the FWT and the nurse manager. Another described the student's performance as a reflection of the FWTs' teaching ability and another specifically identified the difficulty of role modelling in the assessment process. When this issue was explored in the case-study the feelings generated by the concept were clearly demonstrated and related to both negative and positive role models. One lecturer described these feelings saying "...or else you get the opposite reaction - my fieldwork teacher did this - I think that's appalling - I'd never do that in my life and I think I tended to go towards that pole (rather) than role modelling - (it was) very much negative role modelling. I was absolutely adamant I would not do what Mary Bloggs did and I tried very hard professionally to stick to that..." Concern was also expressed about the level of competence of practice demonstrated by some FWTs who were perceived as a role model by the student. This was illustrated with the comment "...there's one I've got in mind who I felt was rather a lumpish fieldwork teacher ... turned out to be absolutely brilliant with a student who said last week that she would never have got through without her - I'm concerned that students will mirror that fieldwork teacher...". Interestingly another lecturer described the enthusiasm of the FWT as more influential on the students than role modelling saying "...I do think if you've got an enthusiastic fieldwork teacher you've got enthusiastic health visiting...". However, Dotan et al (1986) argue that enthusiasm

is one of the attributes in teachers which is responsible for them being a role model to their students. Furthermore I would suggest that the enthusiasm demonstrated in practice is also pertinent to the development of an appreciation of the concept of professional artistry and therefore has implications for student learning and the assessment process. It is also significant that the concept of role modelling emerged when discussing other issues during the semi-structured interviews. This particularly related to both the FWTs' interpretation of the assessment criteria and the base line used to judge the students' performance. This is illustrated by the comment "...I think it's how they reflect the mirror of the fieldwork teacher and I'm worried about this clone business - if you don't appear to be exactly as your fieldwork teacher says you should be what happens?...". Another said "...I think some of them (the fieldwork teachers) are very conscious that they may tell the reader much more about themselves than what it actually says about the student...". I would argue that these issues relate specifically to the paradigm of practice adopted by the FWT, particularly where the FWT has adopted a traditional approach, thereby limiting the interpretation of professional practice. This in turn has implications for the assessment process. The FWTs' perception of the influence of the role model is explored in Chapter 6.

The subjectivity of the FWTs' assessment was identified as an issue of concern in the survey data, particularly by those respondents who questioned the level of competence demonstrated by FWTs in the process of assessment. Although the issue of subjectivity may arise from the student-FWT relationship, Chapman (1979) demonstrated that a proportion of FWTs identified "gut

reaction" as a method of assessing the student's performance. The issue of subjectivity was explored in the case-study by asking the lecturers to describe their perception of the role of intuition in the assessment process. All the lecturers identified intuition as playing a significant role in the process. Its use was related to assessing students' attitudes, to making an initial assessment of the student, to providing a cue for identifying specific evidence about the student's performance and creating bias in the FWT's judgement. One lecturer specifically related the use of gut reaction to assess the communication between the student and FWT. This was illustrated with the comment "...if the student gets on with the fieldwork teacher then they automatically assume that the student is going to be a good health visitor - I have had a student health visitor who I really didn't see eye to eye with, there was no way I felt that my judgement of her as a person should cloud my judgement of her and I decided that she would be an adequate health visitor - but she has since left and had a baby so I was wondering if may be I was right...". It is interesting that two lecturers related the issue of intuition equally to health visiting practice. One commented "...although there is a tremendous body of knowledge and there's a lot of conceptual thought about health visiting there's an awful lot of intuition that something is wrong with this or something needs doing here.". Although the significance of intuition and the intuitive knowing in practice which determines professional judgement has been described in Chapter 1, it is pertinent that Beckman Bloomquest (1985) argues equally for the value of intuitive thinking and personal judgement in the process of student assessment. This concept I would argue has particular implications when judging the performance of the borderline student. Indeed it is the

phenomenon of the borderline student which frequently initiates the legitimate conflict amongst practitioners as to the definition of competence in practice. It is interesting that this does not occur in the obviously competent student and I would suggest this directly relates to the presence of an appreciation of the concept of professional artistry in the student's performance.

Therefore although the lecturers identified subjectivity as an area of concern influencing the validity of the assessment procedure, I would argue the data demonstrate the need to distinguish within the assessment process between subjectivity and intuitive thinking, particularly as this concept plays a significant role in the assessment of professional practice.

### Conclusions

The findings demonstrate that the interpretation of professional knowledge places the emphasis on a traditional paradigm of practice, even while acknowledging those practice issues bound up in an appreciation of the concept of professional artistry. This traditional paradigm indicates a task orientated approach grounded in specific client groups rather than a conceptually based paradigm for health visiting practice. Therefore although the lecturers articulated their concern about the restricted interpretation of health visiting practice presented in the learning experience during the practicum, I would argue that this pattern is reinforced by the lecturers' interpretation of practice, thereby questioning the extent to which the concept of professional artistry is recognised as a fundamental requirement for competence in practice.

The lecturers' perception of the validity of the assessment procedures also demonstrates the conflict created by the lack of a theoretical framework for the assessment process. The need to revise the procedures was specifically related to changes in health visiting practice, once more demonstrating a traditional paradigm of practice. Indeed I would suggest that the interpretation of professional knowledge specifically contributes towards the dilemma in their perception of the validity of the assessment procedure and it is significant that where FWTs had been involved in the design there was less perceived need to revise the procedures. Although the findings demonstrate the importance attached to self-assessment by the student within the procedure, it is significant that the benefit of client participation in the process was not generally accepted. The issue of the client's lack of understanding of health visiting practice was particularly identified. Indeed I would argue that these findings support the evidence attributing the crisis in professional education to the discrepancy between the theoretical interpretation of professional practice and the reality of the practice setting. It also demonstrates the significance of the concept of professional artistry in practice which is currently not addressed in the assessment procedures.

Another significant finding is the lecturers' perception of the influence of the FWT on the validity of the assessment procedure. Two major themes were identified: the FWT's competence in the process of assessment and the FWT's interpretation of professional practice. The lecturers in articulating their concern about the expertise of the FWT related this particularly to the objectivity, personality and teaching skills of the FWT. Although the revised



course in fieldwork teaching was described as broadening the education and training of the FWT, it has not resolved the difficulty of identifying criteria on which to judge the student's performance, (particularly with the borderline student) nor has it resolved the difficulty of committing that assessment to paper. I would suggest this evidence demonstrates that the current course not only does not facilitate the development of an epistemology of practice grounded in reflection-in-action, but also does not facilitate the use of the intuitive knowing in practice which is essential in determining professional judgements. Furthermore I would argue it has contributed to the current confusion experienced by FWTs and lecturers in their understanding and use of subjectivity and intuition in the assessment process. Indeed I would argue these issues have implications for the interpretation of professional practice demonstrated by the FWT, particularly as the data identify the influence of the FWT as a role model. These issues therefore provide the central focus in the analysis of the FWT's interpretation of professional knowledge and their adopted paradigm of practice and the implications for the assessment of competence in practice.

(1) The ENB provide a standardised assessment procedure for the period of supervised practice. The form in use at the time of the empirical work (1984-85) can be found in Appendix A.

## CHAPTER 6

### The development of the practicum in health visiting: a vehicle for the assessment of professional competence

Schon (1987) describes the practicum as the setting in which a student learns a professional practice. The context in which this experience is set, although resembling the practice world, is free from the pressures, risks and distractions of practice reality. This enables the student to learn through actual practice in a protected environment under the guidance of a competent practitioner. Schon suggests it is this setting which will enable the student to attain an understanding and appreciation of the professional artistry demonstrated by the competent practitioner; a concept now considered a fundamental element of professional practice. The extent to which the practicum achieves these learning outcomes depends not only on the interdependent relationship between the learning experience, the teacher and the student but also on the relationship between the theoretical component and the learning experienced in the practicum. The practicum is therefore a central focus in the curriculum and cannot be considered a 'second class' activity.

The learning experience provided by the practicum must represent the essential features of practice. However, learning may be inhibited if either the practical constraints encountered resemble too closely the reality of the practice situation or if too many features of the real world practice are omitted. The teacher, who is perceived in this context as the coach, plays a vital role in the success of the practicum. The task of the coach is defined as

'addressing the substantive problems of a design like task, tailoring his moves to the student before him and building up a relationship conducive to learning' (Schon 1987:167). The interaction between the coach and the student and the dialogue established between the two individuals are fundamental to the learning outcomes. Where a successful practicum has been established it not only provides the student with the opportunity of engaging in her chosen practice in a supported environment but also of rehearsing the skills of her practice under the guidance of a competent practitioner, who has specific responsibility of demonstrating, advising, questioning and criticising the student's practice.

In health visiting education it is fieldwork practice which fulfills the learning context of the practicum. Fieldwork practice provides the student with the opportunity of practising health visiting in a protected environment under the guidance of an experienced practitioner who has undertaken additional training. This concept was introduced into health visiting education in 1966, following a study by a special panel established at the inaugural meeting of the Council for Training of Health Visitors (CTHV) in 1962. Their particular brief was to consider the fieldwork experience provided for student health visitors following the recommendations of the Jameson Report (MOH 1956). The importance of practical training had been highlighted in the report which suggested that the "whole course of training should be practical in approach ... the best form of training would no doubt be attachment to services for experience". (MOH 1956: 134) It is significant in the development of fieldwork practice that this recommendation implies an apprenticeship

approach, thus exposing the student to the reality of practice and patterns of work without necessarily allowing time for the demanding task of instruction and education. However the report also recognised that those health visitors providing this experience for the student would need some form of training. The initial scheme was a basic ten day course which was extended to thirty days in 1967 (CETHV 1975) and it was not until 1968 that the Council gave letters of recognition to Fieldwork Instructors (1) who had satisfactorily completed the training.

The fundamental role of good fieldwork experience in student training was continually acknowledged by the Council. It maintained that the introduction of training for FWTs would automatically improve the quality of fieldwork tuition (CETHV 1975). However by 1975 although it was agreed that the quality of practical work had improved this did not compare to that experienced in the theoretical component of the course. The Council in maintaining a philosophy of the 'provision of good fieldwork training' as the corner stone of all professional training (CETHV 1975:3) recognised the need to reconsider the training offered to FWTs. In 1976 a working group was established by the Council with a broad remit to:

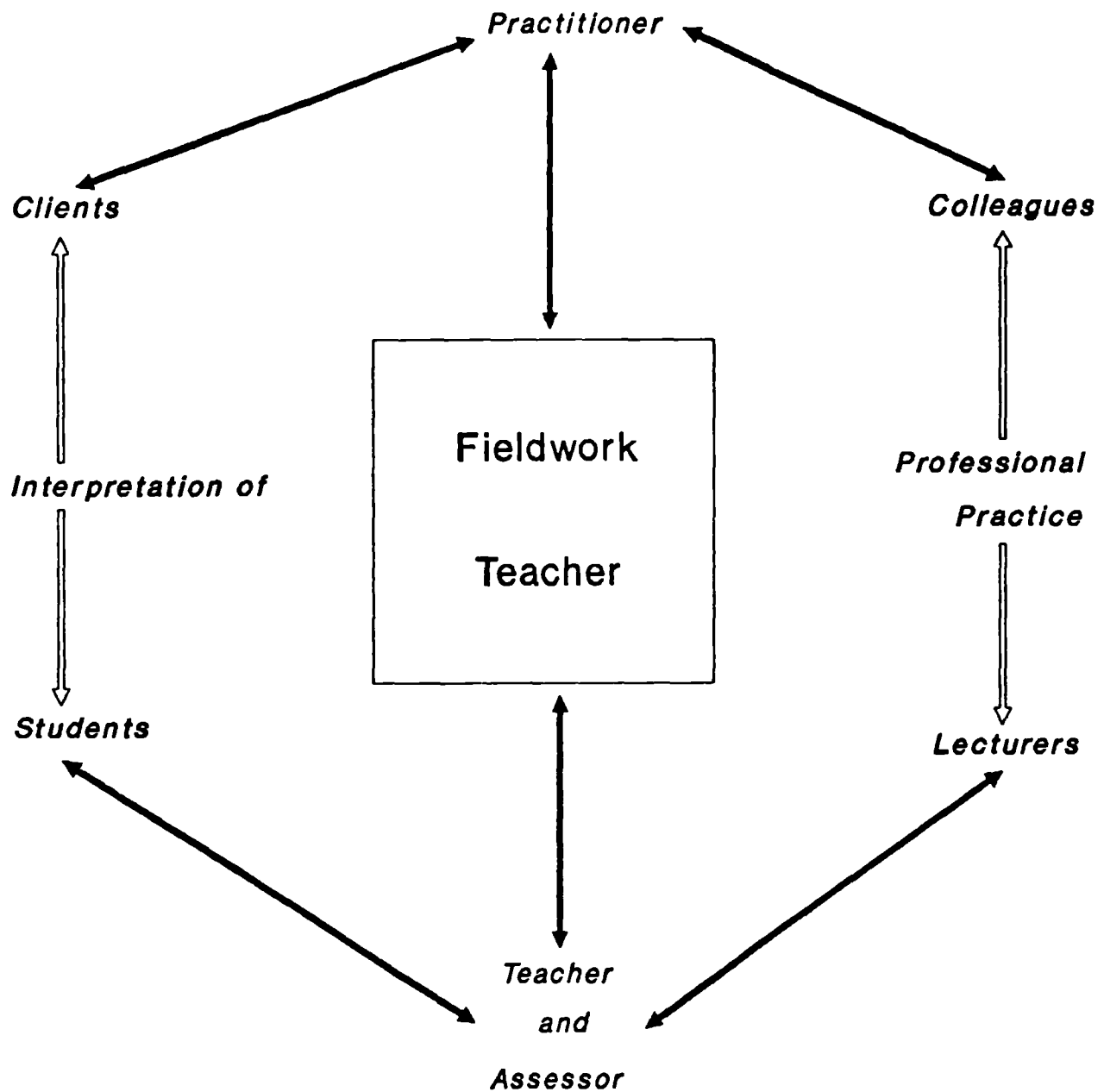
- i) review the work of the FWT and the required education and training to undertake this role,
- ii) determine the Council's award for those individuals successfully completing the courses,
- iii) consider the resources required for the introduction of the proposed courses in fieldwork teaching. (CETHV 1977a)

The working group argued that it was unrealistic to implement changes which would result in any major expenditure in a time of financial constraint. The model of the six week theoretical component was therefore maintained but an extra probationary year was introduced. This provided the opportunity of introducing the concept of supported teaching practice for the FWT. This was referred to as part II of the FWT course. The supervision for the FWT during this time would be the responsibility of the health visiting lecturing staff at the Institution where the student health visitor was registered. The level of performance demonstrated by the FWT was to be assessed by the lecturer in health visiting and a nurse manager. The course content was based on the perceived needs of the FWT and the revised curriculum was introduced in 1977. At the same time the requirement for course validation was introduced by the CETHV in an attempt to monitor the standards of individual courses. It is this revised course which provides the current training for FWTs.

In health visiting education the teacher's role in the practicum is increased by the additional responsibility of assessing the student's competence in practice. The description of the role of the FWT provided by the ENB specifies 'teaching the practical aspects of health visiting demonstrating the required skills and attitudes appropriate in a variety of social and family settings and providing the opportunities for the health visitor student to practice, develop and extend their health visiting skills. The FWT also assists in the assessment of the student's potential to become a competent health visitor' (CETHV 1983a). It is significant however that although the revised course provides the successful FWT with a certificate, acknowledging the value of

fieldwork teaching (CETHV 1975B), the FWT's assessment of the student's competence in practice is not considered on its own merit at the Intermediate Examination Board but is incorporated into the report provided by the lecturer in health visiting when giving an overall assessment of the student's performance. This I would argue makes it difficult for those involved in health visiting education to have confidence in the professional judgement of the FWT. This supports the finding in Chapter 5.

The approved syllabus for the FWT course describes the concept of the FWT as a learning resource for the student by providing a role model (CETHV 1982:16). This obviously has particular significance for the level of professional competence demonstrated by the FWT. Although professional knowledge is considered a fundamental component of competent practice, Schon (1987:13) argues it is the appreciation of professional artistry in the practitioner which distinguishes the truly competent practitioner. This argument is supported by England (1986) in his discussion on the concept of intuition in social work where there are many similarities in practice to health visiting. It is essential therefore that the role model provided by the FWT demonstrates these vital elements of professional practice. In addition to providing a role model for the student the FWT must also continue in her practitioner role, thus being accountable to the Health Authority, clients and colleagues. Figure 6.1 demonstrates the interaction between these roles which I would argue has intrinsic implications for the student's learning in the practicum, particularly considering the stress imposed on the FWT by her continuing role as a practitioner (Dean 1985:95).



The interaction between the professional roles of the fieldwork teacher

Figure 6.1

The other component which must be considered in the practicum is the learning experience provided for the student. However I would suggest that the FWT's continuing responsibility to her caseload and in particular her workload, limits the amount of control she can exercise over the provision of the learning experience. Specific issues such as caseload size, the practice situation and the type of health visiting intervention offered to the client have implications for the practicum. However, the learning experience will also be influenced by the FWT's interpretation of health visiting practice. Chapter 1 describes some of the different paradigms of practice adopted by practitioners and indeed individual practitioners will develop different frames of reference for situations experienced in the practice setting. A particular example of this type of situation is the establishment of Community Initiatives in health (Somerville 1985). The opportunity for the student to experience different frames of reference and practice issues in a supported environment will obviously have implications in the process of assessing competence in practice.

I would argue therefore that specific factors in the practicum generate issues which are significant in the process of assessing the student's competence in practice and thus provide a framework for the analysis of the data acquired from the questionnaires, the semi-structured interviews and the student assessment procedures completed by the FWT. These issues are:



- i) The FWT's perception of the nature of professional knowledge in relation to the assessment procedures;
- ii) The practicum and the conflicting demands experienced by the FWT;
- iii) The paradigm of practice presented to the student;
- iv) the learning opportunities provided for the student in the practicum;
- v) The influence of the student on the outcome of the assessment process.

These issues will be explored sequentially to establish the extent to which the existing practicum facilitates the interpretation of professional practice and the process of assessing the student's professional competence in practice.

The FWTs' perception of the nature of professional knowledge in relation to the assessment procedure

As described in Chapter 2 the ENB require the FWT to submit written reports of the student's progress in the practice setting and the final report must provide evidence of a satisfactory level of competence to the Examination Board. Although the practicum constitutes approximately one third of part one of the health visiting course, the FWT is the only professional to have continual contact with the student during this time. It is perhaps this type of issue which has generated the interest in the

process of assessing competence in the practicum demonstrated not only by the initial survey of lecturers in health visiting in England, (Chapter 4:108) but also by the FWTs in the case study college. 24 of the 27 FWTs completed the questionnaire providing a 89% return rate and all 13 FWTs selected for the semi-structured interview agreed to take part. However, before exploring the FWTs' opinions of the assessment procedures, the issue of their training in fieldwork teaching requires addressing as the course having changed both in structure and content during the last ten years, may influence the FWTs' perception of the assessment procedure.

The FWTs: a profile of their professional experience and training in fieldwork teaching

TABLE 6.1

years since qualifying			not required to complete part 2		
	number	%		number	%
Part 2	8	33			
1-3	9	38		0	-
4-7	3	13		1	4
8-11	3	13		3	13
12+	1	4		1	4
N =	24	100		5	21

The Length of Time Qualified as a FWT

Table 6.1 demonstrates that 17 (71%) of the FWTs involved in the case study had been qualified for less than three years. 8 (33%) of the group were completing their FWT course. Dean(1985) comments that this group were excluded from the sample in her

TABLE 6.2

years qualified	adequately trained		inadequately trained		undecided		sufficient input		insufficient input	
	number	%	number	%	number	%	number	%	number	%
part 2	6	25	1	4	1	4	7	29	1	4
1-3	6	25	3	13	0	0	5	21	4	17
4-7	3	13	0	0	0	0	2	8	1	4
8-11	3	13	0	0	0	0	1	4	2	8
12+	1	4	0	0	0	0				

N = 24

The FWTs perception of the management of the topic of student assessment in the FWT Course

study as it was considered that their involvement might impose needless pressure while becoming familiarised with their new role (Dean 1985:35). I would argue that in the current study it would have been inappropriate to exclude this group as they maintain their responsibility for assessing the students' competence in practice. The table also demonstrates that only 5 (21%) of the sample were not required to undertake a probationary teaching year, thus

indicating that the majority of the FWTs had been involved in a similarly structured course. However, there may have been discrepancies in subject content as the courses had been completed at several different Institutions.

If these figures are compared with Table 6.2 it is clear that those completing Part II of the course did not experience any greater uncertainty in the process of assessing competence in practice than other relatively inexperienced FWTs. Those FWTs who considered their training inadequate or were undecided in their response linked this to inexperience rather than lack of expertise indicated by comments such as: "Hopefully by the end of part 2 having had and assessed one Student and passed I will be able to answer in the affirmative". A lack of experience was cited equally by those FWTs in the 1-3 year band with any insecurity in the role of assessor related directly to inexperience. Indeed only one FWT stated that she needed more detail in assessing the student objectively.

There was no connection in the data between FWTs feeling inadequately trained and not having completed the revised FWT course. However this may be explained by the fact that those five

practitioners had participated in either updating courses for FWTs or professional courses which they considered enhanced their skills in assessment. However one respondent again directly related expertise to experience stating " I can say yes now but on reflection I don't know that I was when I trained as a FWT." Although the majority of the sample stated they were adequately trained, this was qualified in some instances by the statement that they had not yet experienced a difficult student, rather than expressing confidence about the nature of the professional practice which they were assessing.

However, a discrepancy is apparent if these figures are compared to those FWTs who considered there had been sufficient input on the topic of assessment in the FWT course. 8 (33%) stated there had been insufficient coverage but only 4 (17%) felt inadequately trained. This was greatest in the 1-3 year band and suggests that the FWTs either do not recognise their lack of expertise or additional training is being acquired elsewhere. The predominant theme demonstrated in the comments was the difficulty of covering the topic from a 'theoretical perspective'. The comment that "so many factors become apparent when the student FWT is carrying out her first assessment" was echoed by other respondents. The need for "ongoing discussion" was also cited. These reasons may account for the dissatisfaction with the theoretical input on assessment peaking in the 1-3 year band.

I would argue that the data suggests that experience plays a significant part in the FWTs' perception of their skill in the assessment procedure. It is disturbing that the majority of FWTs did not consider that professional knowledge or interpretation of

health visiting practice had any bearing on their ability in carrying out the assessment process. It is particularly significant that none of the respondents identified the intuitive knowing in practice which informs and determines professional judgement as an area of practice in which they felt inadequately trained to assess. However the factors influencing the students' ability to attain this concept are acknowledged repeatedly as an important area of competent practice. The emphasis placed on experience rather than expertise suggests that the actual procedure takes on a much greater significance in the process of assessing the student's level of professional practice, particularly in relation to fulfilling the demands made by changes in health visiting practice and the requirements of the Statutory Instrument (1983 no. 873).

The relationship between the nature of professional knowledge and the assessment procedure: the FWT's perception

At the time of the empirical work, the assessment procedure used to assess the student's professional practice involved the FWT in completing two virtually identical forms which constituted the formative and summative assessment of the student's professional competence (Appendix I). The formative procedure was completed at the end of the first term and the summative on completion of fieldwork practice in the third term. The procedure was designed by a working party of FWTs and the researcher and was introduced as a pilot study during the academic year 1983-84. Following revisions it was implemented for general use at the beginning of the academic year in which the study was undertaken. However, it has also been demonstrated that FWTs use informal methods when

assessing the students competence in practice (Dean 1981:156). The FWTs perception of the assessment procedure has therefore been divided into two categories: formal procedures and informal procedures.

#### The formal assessment procedure: the structured report

The aim of the college working group in providing the assessment procedure was to design a structured form which would be appropriate for the different paradigms of practice adopted by FWTs. Indeed it has been acknowledged that it is both difficult and inappropriate to draw up a finite list of health visiting experience (CETHV 1975:3) as has been discussed in Chapter 1. The college working group therefore decided the most appropriate format to adopt was a skills approach based on the eight major skills of health visiting defined by the Curriculum working group (CETHV 1981). The second stage of the procedure was designed to assess the interpersonal skills of the student and the third stage allowed the FWT and the student to comment on any particular strengths and weaknesses in the student's practice. The summative procedure in addition required the FWT to state whether the student was competent to go onto supervised practice. Despite concerns expressed in the literature review regarding 5 point rating scales (Klimoski and London 1974) this was selected as the most relevant for the assessment procedure. Once more, it is significant that the procedures did not address the important but more indeterminate spheres of professional practice such as the appreciation of professional artistry.

However the design of the formal assessment procedure generates three specific issues which require addressing:

i) whether the procedure assesses the student's competence in professional practice.

ii) whether the rating scales facilitated the process of assessing the student's competence in practice.

iii) whether the rating scales reflected the level of student performance in practice.

TABLE 6.3

	number	%
Structured form	19	79
Free-written report	4	17
Undecided	1	4
N =	24	100

The Fieldwork Teachers' preference for the type of assessment procedure.

Table 6.3 demonstrates the FWT's preference for a structured assessment procedure. A fundamental issue to emerge from the data analysis was the reluctance of many FWTs to take responsibility for interpreting the nature of professional knowledge. This was demonstrated by comments which acknowledged that the procedure enabled them to identify the component of the student's practice which required assessing. Other respondents developed the issue further by specifically stating that they were concerned their interpretation of professional knowledge would omit areas of practice considered important by other practitioners. It is significant that some respondents demonstrated a feeling of relief



that the responsibility for the interpretation of professional knowledge had been clearly placed with the college. Indeed I would argue that it is an area of professional concern that the majority of the FWTs perceived the assessment procedure as a method of identifying the nature of professional knowledge. It is also significant that the majority of the cohort perceived professional practice only in terms of skills, ignoring practice issues such as an appreciation of professional artistry. The restricted interpretation of professional knowledge was demonstrated further when the FWT's were asked to identify any particularly difficult areas of the assessment procedure.

Although 8 (33%) of the respondents were unable to identify any specific areas 2 (8%) related this once more to their limited experience of student assessment. This finding is supported by comments such as " I have only the experience so far with one student - I didn't find it difficult assessing her". However the majority were able to identify features, and the dominant theme related to the assessment of the interpersonal skills of the student. Four specific categories were identified: self awareness, perception, sensitivity and the ability to relate to clients. The issue of subjectivity was particularly identified and this was indicated by comments such as "it is more difficult to put one's finger on personal qualities and their implications". The ability to assess the student-client relationship was also cited as a difficult area to assess especially when the student was home visiting. Although Dean (1985) states that FWTs assess the interpersonal skills while visiting clients with the student, other research (Clark 1984, Kratz 1975) has shown that the presence of a third person in the interview alters the

relationship between the client and the student. This may be more significant when the third person is well known to the client as in the case of the FWT. However I would argue it is significant that although the FWTs specifically identified factors which directly influence the students ability to develop an appreciation of professional artistry, these factors could not be identified in the FWTs' interpretation of professional knowledge.

Some members of the college teaching staff had been hesitant about the introduction of a formal structured procedure, suggesting it would impose extra work on FWTs who were already expressing difficulty in accommodating their professional commitments. The semi- structured interviews were therefore used to explore this concept by asking the interviewees if they had found the procedure a tiresome task to complete. This word was chosen specifically as it could be interpreted in several ways such as irritating, laborious, boring or tedious. Only 3 of the 13 participants described the task as tiresome. However in each case it was acknowledged that the process was a useful method of assessing the student's competence in practice. The value of the procedure was identified by the other interviewees. One FWT stated " I found it really useful- we both found it valuable to actually set an afternoon aside to go through something- I mean you tend to do it all the time anyway to go through performance and evaluate but to actually sit down and have quite a structured way of doing it was very useful". It is comments such as this which demonstrate the way in which the FWTs used the procedure to facilitate the dialogue about the nature of professional knowledge. However, I would argue the data also suggests that the FWTs experienced difficulty in initiating this type of dialogue which is essential

in an effective practicum. The feelings experienced by the FWTs in completing the procedure was an important phenomenon to emerge from the data. They expressed surprise at the difficulty they had encountered despite being experienced FWTs. This was partly attributed to the complexity of the process, however they also expressed other concerns such as feelings of inadequacy and anxiety in how they assessed the student's performance and committed that judgement to paper. Some FWTs particularly related their concern to the amount of time the student spent in the practicum which influenced the time available for their assessment. One FWT stated that she considered the expectations of many assessors too high and commented that the student remained very inexperienced by the end of the academic year. I would suggest this statement represents a fundamental concern in the process of assessment, the confusion demonstrated by FWTs in distinguishing between lack of competence and lack of experience. Indeed I would argue this demonstrates once more the lack of an effective dialogue between the student and FWT.

An additional finding in the data demonstrated the different techniques employed by FWTs in actually completing the procedure. These ranged from the negotiated to the imposed. Although those FWTs who described themselves as negotiating the completion of the procedure appeared to be facilitating the development of skills in self-assessment the actual amount of negotiation varied with individuals. One FWT stated she had negotiated over the student's point on the rating scale but had kept the comments the same. Another example is provided by the FWT who commented " I usually ask the student to assess herself - what they would put and then I say what I think and they do agree with it ..... I can't remember

anything we disagreed about" which suggests that in reality very little negotiation actually takes place between the assessor and the student. Significantly no distinction was made between the procedures used to complete the first and final assessment despite a specific policy of formative and summative assessment. Therefore although the assessment procedure facilitates the initiation of a dialogue between the FWT and the student I would suggest in reality few FWTs use this opportunity to debate practice issues and situations. Indeed I would argue that the data suggest that many of the students experience a practice setting resembling the technical training associated with an apprenticeship model of training rather than the reflection-in-action which is necessary to enable the student to develop as a competent practitioner.

The data clearly demonstrate that, although the majority of the FWTs found the structured procedure useful, it fosters the restricted interpretation of professional knowledge described in Chapter 1. In addition the structured form also required the FWT to rate the student's performance on a scale of 1-5 ranging from excellent to poor. It is implicit within the use of rating scales that the FWT is responsible for measuring the level of the student's performance in specific areas of practice. However the previous discussion has identified the difficulty of assessing those important elements of practice, such as the intuitive knowing in practice involved in determining professional judgement and I would suggest the application of rating scales adds to this dilemma. It was therefore important to explore the FWT's perception of the use of rating scales in relation to their understanding of professional knowledge and the implications for

assessing the student's competence in practice. In this context two further issues in the design of the formal assessment procedure require addressing:

- i) the use of rating scales in facilitating the process of assessing the student's competence in practice;
- ii) the use of rating scales in reflecting the level of student performance in practice.

#### The use of rating scales in facilitating the process of assessing competence in practice

Although the use of rating scales as a method of assessment has previously been discussed (chapter 4:110), as the technique had been implemented in the assessment procedure it was therefore important to explore the FWTs perception of the use of rating scales in relation to the nature of professional knowledge. It is interesting that the only disadvantage identified in the structured assessment form was that some FWTs considered it limiting as a method of assessing student performance and this concept was related specifically to the use of the "grading system". This was demonstrated by the comment "I don't find the box format allows enough individuality of approach - it is difficult to show subtleties in progress or difficulties". However when the topic of rating scales was raised during the interviews several positive characteristics were identified. The predominant theme related to facilitating the task of the assessor. This related both to the procedure and identifying aspects of the student's practice. The ability to think more in depth about the assessment was also identified. Respondents

stated "it was much more clear cut - you could pick out instead of being in between and a bit waffley" and "you've got to have some form of guideline you don't know what you're measuring otherwise". However it is significant that these observations had also been cited as advantages of the structured assessment form and I would argue that the data demonstrate that the FWTs have not discriminated between the use of the structured form and the use of rating scales. It also suggests that the ratings were not implemented against specific criteria on which to judge performance but only provided a general basis for the assessment. Indeed Bondy (1984:25) suggests that the contribution of rating scales to student assessment depends not only on "the specificity of the behaviours evaluated but also on the clarity with which each graduation in a series of scale points is defined". I would argue therefore that the rating scales are merely being used as an aide-memoire in the process of assessing the student's competence in practice.

The disadvantages identified by the FWTs in using rating scales related to the limitations of the technique. The use of the middle rating was particularly highlighted. The FWTs described themselves using this rating because the student's performance "had not been proved either way" or "because I find it very difficult to go to the other - the poor side". The subjectivity of "just putting a mark without qualifying it" was also identified. Although some FWTs expressed concern that the students did not always fit the categories provided by the rating scale, they did not provide any specific reasons for these observations. In addition I would suggest that some FWTs identified areas of professional practice within the student's performance which were

not reflected in the rating scales. Although the data provides evidence to demonstrate that some FWTs perceived the rating scales facilitating their task in assessment process, I would argue this does not relate to the nature of professional practice but to the technical processes involved in the procedure. Indeed some FWTs specifically stated that the rating scales made them think more clearly about the processes involved in the procedure. Other FWTs specifically identified the use of rating scales limiting their assessment of the student's competence in practice, particularly I would suggest in the more indeterminate zones of practice (which however are essential for the competent practitioner).

The use of rating scales as a reflection of level of student's performance in practice

TABLE 6.4						
Ratings	1	2	3	4	5	N/A
Observation	4	32	20	0	0	0
Communication	7	53	58	8	0	14
Assessment	2	10	35	3	0	6
Management	1	21	31	4	0	27
Advising	6	25	49	3	0	1
Teaching	2	6	1	1	0	46
Evaluation	5	34	39	5	0	1
Perception	4	34	17	1	0	0
Sensitivity	6	34	41	2	0	1
Self-Awareness	3	26	23	2	0	2
Professionalism	5	19	4	0	0	0

FORMATIVE ASSESSMENT

Ratings	1	2	3	4	5	N/A
Observation	12	41	3	0	0	0
Communication	43	74	22	0	0	0
Assessment	10	40	6	0	0	0
Management	19	42	18	0	0	2
Advising	19	53	9	0	0	0
Teaching	18	26	8	0	0	2
Evaluation	19	44	17	0	0	1
Perception	18	33	4	0	0	1
Sensitivity	30	37	16	0	0	1
Self-Awareness	17	30	9	0	0	0
Professionalism	18	9	1	0	0	0

SUMMATIVE ASSESSMENT

The allocation of student ratings in the formative and summative assessment procedure

Table 6.4 demonstrates the allocation of ratings in both the formative and summative assessment procedure. It is interesting that Category 5 had not been used throughout the entire procedure. However Squiers (1981:166) demonstrated that nurse supervisors openly expressed their fear of being asked to account for low ratings by senior colleagues or tutors. Others saw a low rating as a failure on their behalf. Although category 4 was not used in the summative assessment, its use in the formative assessment predominantly demonstrated a lack of experience in the skill rather than the level of performance. This was indicated by comments such as "she has not had much experience in using other agencies yet" and "the ability to use other agencies appropriately will improve with experience and opportunity next term". However the nonapplicable category had been well used, despite evidence in the study by Squiers (1981) demonstrating that nurse supervisors considered the use of this category as 'failure' to provide the student with an adequate training. Nonetheless it is pertinent to note that the only skill which was considered appropriate for assessment by all FWTs was that of observation. This may be explained by the fact that it is expected that this skill will have been acquired during previous training. However, it is disturbing that skills which pertain particularly to health visiting practice such as communication and teaching were considered inappropriate criteria in the formative assessment by some FWTs. Indeed I would suggest the omission from the formative assessment procedure reflects some FWTs limited understanding of the nature of professional knowledge.



TABLE 6.5

	A - FORMATIVE			B - SUMMATIVE		
Ratings	1	2	3	4	5	N/A
Total A	45	294	318	29	0	98
Total B	223	429	113	0	0	7

A comparison of total ratings allocated in the assessment procedure

Table 6.5 demonstrates the shift in emphasis in the allocation of ratings in the two assessment procedures. A greater use of the middle rating was made in the formative assessment, once again indicating the association with lack of experience rather than ability. In the summative assessment the majority of the ratings were allocated to the two highest categories. This corresponds to raters performance in other research studies (Dobby 1981, Squier 1981). However it is interesting that one particular student was rated 3 for every category throughout the two procedures. Schon (1987: 168) suggests that this may reflect the rater and her ability to encourage a reflective dialogue with the student rather than the ability of the student. It is perhaps significant that this particular FWT also did not return the questionnaire. Hedges (1978) suggests that the nonrespondent provides a valuable source of data to the researcher.

The allocation of a rating to a category which clearly allowed room for improvement emerged as a predominant theme in the data. This is supported by comments such as "I used the middle column knowing I've got to leave lee way for them to go up", "it's a

temptation to use that middle of the road - they've got to improve everyone can't be excellent in the first term as there is no room for improvement". A further disturbing fact was that 2 FWTs rated performance that they specifically stated they had not observed the student practise. This once again demonstrates the lack of dialogue between the student and FWT and raises serious questions about the extent to which the practicum provides the student with an effective learning environment.

Inconsistency in the ranking of the students' performance was demonstrated by a significant proportion of the FWT cohort. 7 (29%) of the FWTs rated certain categories of the students' performance lower in the summative than in the formative assessment. In all but one case this was only through 1 rating point. However one FWT had lowered the student's ratings in 11 different categories without making any comment. This phenomenon occurred predominantly within the skills of assessment, communication and evaluation, all essential components of health visiting practice. Squier(1981) demonstrated a similar pattern and offered the explanation that raters become more critical as they became more experienced in using rating scales. The data obtained during the semi-structured interviews suggests that this shift in ratings may be accounted for by the baseline established for rating the students' performance. When the FWTs were asked to identify the baseline they had employed their answers included: never having thought about the concept, openly admitting they did not know, using their own practice and using the individual student's practice. This confusion is perhaps further illustrated within the actual assessment procedure. Only one FWT made a statement describing her criteria for establishing the student's

baseline. Others used words such as "enjoyed" to describe the student's performance in certain skills. The inconsistency amongst raters was clearly illustrated by one respondent who commented "well that's what's so ridiculous we're all rating it against totally different things".

The inconsistency in the ranking of performance is supported further by the comments included on the student assessment form. The importance attached to the use of comments in the procedure has previously been highlighted. However it is interesting that 6 (25%) of the FWTs did not make any written comment on the students' performance during the formative assessment. One respondent in this group made no comment on the student's health visiting skills in either assessment procedure. I would argue that this is a disturbing phenomenon as there is evidence to suggest the rating does not reflect the level of performance. This is particularly illustrated in the summative assessment in the category 'organising and running a Child Health Clinic' (CHC), another essential component of a traditional paradigm of practice. 11 (46%) of the FWTs rated the students' practice in the middle category. However 7 of these respondents related this to a lack of opportunity rather than the students' skill. A further illustration of the inconsistency in ranking is provided by one FWT's comment on the summative procedure, which indicated that the student had experienced difficulties in the past in being non-judgemental towards clients. However there was no indication of this in the ratings on the formative assessment. This observation is particularly disturbing as this issue relates directly to the factors influencing the student's ability to develop an appreciation of professional artistry.

The data demonstrate that the FWTs used the rating scales to indicate areas of practice where students lacked experience rather than ability in performing practice skills. This is particularly demonstrated in the use of the middle rating in the formative assessment procedure. The FWTs also used the rating scales to allow 'room for improvement' in the student's performance rather than to identify particular strengths and weaknesses in the student's practice. The inconsistency in the rating of performance was demonstrated. In particular this relates to the lack of consensus amongst the FWTs in selecting an appropriate baseline on which to judge the student's performance. However the most significant finding in the use of rating scales relates to the interpretation of professional practice demonstrated by the FWT. The data demonstrate that many FWTs considered specific practice skills identified in the assessment procedure inappropriate to the formative assessment process. However these skills, which include communication and teaching, are essential components of competent practice. I would argue therefore that although the use of rating scales did not reflect the student's level of performance, it does reflect the perception of professional practice of a proportion of the FWT cohort. I would suggest this finding seriously questions the effectiveness of the practicum and has implications for the assessment process.

Indeed the findings in the data not only demonstrate the difficulty experienced by a significant proportion of the cohort in defining the nature of professional knowledge, but also the restricted interpretation of professional practice portrayed in the procedure. It is significant however that the assessment

procedure also identified those areas of professional knowledge which were extremely difficult to assess but considered essential for the competent practitioner. The interpersonal skills of the student: self-awareness, perception, sensitivity and the ability to relate to clients, (factors influencing the appreciation of professional artistry) were included within this interpretation of professional knowledge. In addition the intuitive knowing in practice which is considered essential to competent practice was not addressed in the assessment procedure and I would suggest it is significant that none of the FWTs commented on its omission; a phenomenon once more demonstrating a limited interpretation of professional knowledge.

The FWTs' perception of the informal methods used to assess the students' competence in practice

Despite the structured assessment procedure providing a grounding for the FWTs in the interpretation of professional practice, I would suggest it did not facilitate their task of observing the students' skills in the practice setting, nor the particularly difficult task of assessing those qualities and skills such as empathy, counselling and listening. A similar difficulty has been identified by Dean(1981), who described six methods employed by FWTs in attempting to overcome this problem, including: the use of students' reports, (both verbal and written) of visits to the study families, the use of self evaluation by the student, reports by families and student participation in case discussion. The reports from families were described as an "undercover" method. In the present study these classifications were considered as a basis for analysing the data to establish the FWTs perception of

the informal methods used to assess the student's competence in practice and the following categories were identified:

- 1) student self assessment
- 2) feedback from colleagues
- 3) feedback from clients/families.

**TABLE 6.6**

	useful	%	not useful	%	undecided	%
Student self-assessment	20	83	2	8	2	8
Feedback from colleagues	21	88	2	8	1	4
Feedback from clients	18	75	5	21	1	4

N = 24

Informal methods used by the FWTs in the process of assessment

Table 6.6 demonstrates that 20 (83%) of the respondents considered self-assessment a useful informal method of assessment. Those who disagreed described the concept as too threatening as it made the student "feel hopeless in already stressful situation". It is interesting that these statements suggest that the process is a negative experience for the student and perhaps question the FWTs' perception of the process of self-assessment. Of those undecided one related it to personality stating "it takes a fair amount of maturity (not necessarily age wise) to be completely candid about oneself". The other considered the concept a useful informal procedure but was unsure about it as a formal procedure. Jarvis and Gibson(1985:88) describe the skill of self-assessment as a

fundamental component of good practice. This finding is supported by Schon (1987) who suggests it is central to the concept of reflection-in-action. Indeed I would argue that for the student to develop as a competent practitioner, it is essential for the FWT to analyse her own practice and enter into a dialogue grounded in reciprocal reflection-in-action. However if the FWT feels threatened by the process of self-assessment (as is suggested by the findings of the data) the student will be disadvantaged in understanding this important concept in professional practice. Those who described the concept as useful related this to the value of the procedure for the student, FWT and practitioner, particularly in assessing self-awareness and professional growth. One FWT described "knowing oneself as the most important part of health visiting work". Self-assessment was also seen as stimulating further discussion, by providing a central focus to the FWT-student dialogue. An additional finding in the data identified self-assessment as a method of removing any hidden agenda from the formal assessment process.

The questionnaire asked the FWTs whether they took into account any comments made by their colleagues when assessing the student's performance. Although Table 6.6 demonstrates that 21 (88%) of respondents considered feedback from colleagues, it was not possible to establish from the analysis whether they considered this process useful in the assessment process. The analysis did however demonstrate that colleagues' comments were used to substantiate or negate the FWT's own feelings about the student's performance. This particularly related to concerns such as the absence of professional development, irritation with the student and an overintensity in the student's reaction to clients. It

is interesting that considerable value was placed on information obtained from this source. Objectivity was also described as an advantage of this informal method of assessment. This related to the FWTs' concern that bias may exist in the assessment process as the students were 'their students'. In addition colleagues were also used to extend the assessment process. Significantly, this frequently involved providing experience in Child Health Clinics where the colleague would then assess the student's competence in practice. Home visiting was included in the scheme, with one FWT stating "as I like my students to go out with other health visitor colleagues and school nurses it is usual to have their comments on my student's behaviour". I would argue that this method supports Dean's (1981) description of undercover assessment and is unethical unless the student has been informed that the process of assessment involves other professional workers. It also questions once more the extent to which the student-FWT dialogue is used within the assessment procedure.

None of the respondents identified any difficulties in using colleagues comments. There was no comment on colleagues' lack of skill in the domain of assessment as was expressed when discussing clients' comments. Although FWTs stated that they used these comments to substantiate or negate their feelings about the student's level of performance, only 11 (46%) agreed it would be useful to have their assessment validated by another FWT. I would argue that this discrepancy in findings can be explained in terms of role theory, as the conflict between the roles of teacher and assessor must enter the arena. This concept is discussed in more depth in the discussion on the conflicting demands created by the



practicum. (see p. 198 below).

When asked if clients' comments were considered in the assessment procedure 18 (75%) of the respondents stated that they were. 5 (21%) did not include these comments and the reasons stated included the fact that clients were not qualified or trained to assess the student's competence in practice. Others stated that the views of clients might be subjective or biased. These feelings were summarised by a FWT stating "sometimes advice that is 'good' is not always what the client wants to hear. Equally clients should not judge students - they're not trained it's unfair to the health visitor student". I would argue that this finding is very disturbing in view of the recent developments in practice which specifically identify the importance of client participation in the provision of health visiting intervention and provides further evidence highlighting the FWTs' interpretation of professional practice. It is also significant that although the issue of subjectivity emerged as a dominant theme in the analysis of client involvement in the assessment process, only one FWT raised it when discussing professional involvement in the process.

Those FWTs using client comments considered them a useful method of informal assessment. This particularly related to assessing the students' competence in practice when home visiting alone and to the issue of consumer satisfaction. The client was described as being "at the receiving end of the teacher - learner process". The independent view that clients offered was also valued. One FWT stated that she used clients' comments "because practical competence is to me also measured by client satisfaction- this is vital". The comments were considered a reflection of the student -

client relationship and were interpreted as an indication of the student's performance once qualified. When pursuing these issues with the interviewees the spontaneity of the clients' comments was highlighted. This often negated the need for FWTs to specifically request feedback from the clients. However although the comments were described as useful, the caution associated with their use was clearly identified. This is illustrated with the comment " I would take these into consideration providing they appeared to be made in a fairly unbiased fashion and that I considered the comment valid - after all the client is the consumer". I would suggest this finding once more highlights the conflict experienced by FWTs in fulfilling the role of teacher, assessor and practitioner simultaneously.

I would argue that the findings demonstrate that the FWTs use informal methods of assessment to supplement the formal assessment procedure. However the use of colleagues has particular implications if practitioners are not familiar with the purpose of the practicum, or conflicting paradigms of practice have been adopted. Indeed using colleagues in this way may create conflict for the student if these issues are not fully explored in the student-FWT dialogue. The findings also demonstrate the limited capacity of the formal methods in assessing the wider issues encompassed in the interpretation of professional knowledge and I would suggest FWTs overcome this difficulty by using client feedback, particularly when assessing elements of professional knowledge, such as intuitive knowing in practice and the ability to manage the unique practice setting. However the data clearly demonstrate the ambivalence experienced by FWTs in using information acquired in this way. I believe this phenomenon is

created because they not only fail to recognise that much of this process occurs intuitively but also because the client's previous experience of health visiting intervention has been that offered by the FWT. Furthermore the student may demonstrate levels of professional competence, particularly in her understanding and appreciation of the concept of professional artistry, which have not been attained by the FWT. Indeed I would argue that the relationship between the three roles experienced by the FWT: the teacher, practitioner and assessor, creates a professional dilemma and is an issue which requires addressing when exploring the effectiveness of the practicum. The conflicting demands of the practicum therefore provided the focus for the following analysis of the data.

#### The Practicum and the conflicting demands experienced by the FWT

The practicum demands that the FWT demonstrates appropriate skills and attitudes in health visiting practice, provides a learning resource for the student and takes responsibility for assessing the student's competence in practice. Hardy (1978:82) suggests that role conflict occurs when "existing role expectations are contradictory or mutually exclusive". I would suggest that the role expectations of a facilitator, role model and assessor are not necessarily compatible and may indeed be contradictory. In addition the FWT is required to undertake the three roles simultaneously, itself predisposing to role conflict. An important focus for the data analysis was therefore to establish whether the FWTs experienced conflict in their role.

However, as a previous study by Chapman (1979) had identified

assessing the student as the most unpopular role of fieldwork teaching, the primary task was to establish whether the current FWT cohort reflected this finding. Five specific issues in the questionnaire provided the data to explore this hypothesis:

- 1) whether the FWT had requested to do the FWTs course, demonstrating motivation for the role,
- 2) whether the FWT considered it her responsibility to assess the student's competence in practice therefore demonstrating a commitment to the role of assessor,
- 3) whether the FWT felt adequately trained to undertake the role of assessor,
- 4) whether the assessment procedure was a stressful experience for the FWT,
- 5) whether the FWT considered it useful to have her assessment of the student's competence validated by another FWT.

Table 6.7 identifies the responses for each of the respondents in these five areas. I would argue that the FWT who is confident in the role of assessor would be positive about her assessment being validated, have requested to do the FWT course, consider it her responsibility to assess the student (a process for which she felt adequately trained), and not experience any overt stress during

TABLE 6.7

	assessment validated	request course	adequately trained	responsible for assessment	stressful
18	-	+	+	?	+
21	-	+	+	+	-
6	-	-	+	+	-
11	-	-	+	+	-
19	-	+	+	+	-
16	+	-	-	+	+
1	?	+	+	+	-
25	-	+	+	+	+
5	+	+	+	+	-
24	-	+	+	+	-
17	-	+	-	+	-
28	+	+	+	+	-
13	-	+	+	+	-
10	+	+	+	+	-
8	+	+	+	+	-
27	+	+	+	+	+
3	+	-	+	+	-
9	+	+	+	+	+
2	-	-	?	+	-
4	+	+	-	+	-
14	+	+	+	+	-
12	-	+	+	?	+
26	?	+	+	+	-
23	+	-	-	+	+

The factors determining the Field Work Teacher's perception of her role as an Assessor.

the procedure. This would be represented by the following pattern in the above table: + + + + -. Table 6.7 demonstrates that only 5 of the respondents generated this pattern. It is interesting that of those respondents generating a pattern of - + + + - from the data obtained from the questionnaires, only 1 remained negative about the issue of her assessment being substantiated by the time of the semi-structured interviews. I would argue that the data demonstrate that a significant proportion of the cohort experienced ambivalence in the role of assessor which has implications for the process employed in the assessment procedure.

Although none of the respondents denied their responsibility in assessment, two considered it a shared commitment with the lecturing staff. It is significant that these respondents explicitly expressed their difficulty in being both assessor and teacher. The majority of the FWTs attributed their feelings of responsibility for student assessment to their constant contact with the students' experience in the practicum. Additional reasons were identified as having more time for one to one teaching, a knowledge of the caseload and being 'on hand' to discuss the practical experience. The respondents also demonstrated their confusion between the role of assessor and teacher by describing their role in assessment as inevitable since they were responsible for providing the learning experiences for the student.

The FWTs also described themselves as being the only person able to undertake the process of assessment because they were able to observe the students' practice and interaction with client groups. The reality of the practice setting was also identified as important to the assessment process and clearly relates to the concept of the practicum. Other respondents although accepting responsibility stated the assessment should be made in conjunction with another person. Those identified included lecturing staff, FWTs and colleagues. It is interesting that clients were not identified as an appropriate group to fulfil this function despite previously acknowledging that clients' comments played a significant role in the informal assessment process. I would suggest this relates to the conflicting demands of the role of practitioner, teacher and assessor.

The issue of responsibility was pursued further by asking the FWTs if they had failed a student due to incompetent practice. 10 (42%) of the respondents stated that this question was not applicable. It is significant that within this group were not only the FWTs completing the FWT course but also those FWTs who considered their experience too limited despite having had at least 2 students. Other respondents stated that they had been very fortunate in the allocation of the student. One FWT stated that she had failed a student but the college had taken little notice of her concerns or observations, and the student had passed the intermediate examination at the end of the academic year. It is perhaps significant that the student left health visiting after practising for only nine months. Another suggested that the student would require an extended period of supervised practice, which I would suggest demonstrates the FWT's reluctance in taking responsibility for failing the student. This may account for the increasing numbers of students referred in supervised practice which have risen from 1.4% in 1982/83 to 2.4% in 1984/85 (Thwaites 1986). I would suggest these findings demonstrate that although the FWTs accept the responsibility of assessing competence in practice the conflicting demands of the practicum are clearly illustrated. However when asked specifically if they experienced any conflict in simultaneously acting as teacher and assessor 15 (63%) of the cohort had not experienced any difficulties. Nevertheless their comments demonstrated a tone of inevitability rather than a positive commitment. However, the personal responsibility taken by the FWT for the student's performance was acknowledged, with one FWT saying she "would only have herself to blame if there were any glaring omissions or misunderstandings". Another specifically described the assessment as an evaluation of

her teaching. Significantly, neither identified this as causing a dilemma in their role, although these issues relate specifically to the provision of learning experiences in the practicum and the quality of the student-FWT dialogue.

Where difficulties were experienced the dominant theme related to the student-FWT relationship. The difficulty of making criticisms, the influence of the relationship on the actual assessment procedure, the difficulty of becoming a friend to the student and feeling deflated if the student's performance did not come up to expectations were all identified as issues causing concern. The student-FWT relationship and anxiety that the student should be seen to do well were identified as factors which influence the objectivity of the assessment process. A very pertinent observation (made by one FWT) summarised the dilemma for the FWTs saying "in a way the FWT is having to assess and be critical of her own performance". Indeed I would argue that the student-FWT relationship and the concept of the role model are significant factors in the conflicting demands experienced by the FWT and were therefore selected as foci for the semi-structured interviews.

#### Role modelling and the student-FWT relationship: the implications for assessing competence in practice

The relationship with the student is fundamental to the learning environment created in the practicum (Schon 1987) and directly relates to the needs of the adult learner (Jarvis & Gibson 1985:45). Dingwall(1977) demonstrated the high levels of stress experienced by students during the course. The analysis of the



data supports these issues. When discussing with the interviewees whether they were prepared to say more about the student's performance than commit to paper, the FWTs clearly demonstrated their anxiety about damaging the self esteem of the student. This was related to hurting a student already feeling vulnerable, affecting both examination and career prospects and being destructive to the student. Feelings of loyalty were also identified as reasons for not committing comments to paper and related to the fact that the written report was perceived as final and therefore judgemental comments may influence the students' progress. This finding must seriously question the extent to which some FWTs are prepared to include concerns about the student's level of competence in the formal assessment procedure.

The supportive role of the FWT was expressed, for example by feelings of protection towards the student. Offering criticism was an area which was noted as particularly difficult. An important role of the FWT was described as building up the confidence of the student and criticism was perceived as a characteristic which could easily become destructive. However, the role of criticism in the analysis of the student's performance is essential in achieving the aims of the practicum. This observation once more questions the effectiveness of the practicum. The tendency to make allowances in the performances of those students "having a rough time of it .....in either their own personal life or at college " was included in this supportive role. The counselling role was identified with one FWT stating that "with this student I have been more of a counsellor than anything else ....such a lot of personal things which have made it much more difficult". Hunkins (1985) demonstrated the counselling

needs of students and stated that FWTs were ranked second out of eight as the most important person to provide this support. Johnson (1976:117) argues that it is usually the teacher "who sets the tone of the educational relationship". The analysis clearly demonstrates the importance that the FWTs place on their supportive role which I would argue may not only impede the experience of the practicum but also the process of assessment.

The concept of role modelling has been given considerable emphasis by the ENB. Kemper (1968:33) describes the essential quality of the role model as that of displaying techniques and possessing skills which the "actor lacks (or thinks he lacks ) and from whom, by observation and comparison with his own performance the actor can learn". Although this concept has been identified as creating possible conflict in judging student performance the implications of role modelling are considerable in both the analysis of practice and in the understanding and appreciation of the concept of professional artistry. The concept therefore was pursued further during the semi-structured interviews. My observation during the interviews was that this was the only question to raise an immediate spontaneous answer whether positive or negative. The predominant theme was that the FWTs considered that they fulfilled this role. However the issue of inevitability once more was raised illustrated by comments such as " I just don't see how you can not be really". It is significant that they identified this as affecting their practitioner role. The need to be more prepared and thorough was described but the dominant theme was that it made them more aware of their practice and question their own performance. One stated that "I can see this with my first student - seeing things being put into practice - she's rushing

around never writing anything down".

Others stated emphatically that they hoped they were not. This again related to their perception of their practitioner role illustrated by statements such as "I'm not convinced the way I do it is best". It is significant that one FWT actually described the concept as 'frightening' and another refused to answer the question saying 'Oh, God I don't know - what a question - I don't want to answer that' and would not be drawn further on the issue. Although the predominant theme related to the need for the student to be herself and decide her own practice methods, I would suggest that the data demonstrate that some FWTs were disturbed by the concept of role modelling. Implicit in this concept is the acknowledgment that the student's performance is a reflection of the FWT's practice. The feelings generated by this phenomenon are illustrated by the comment: 'I hear her saying things I've said virtually word perfect and I think my God that could be me saying that...'. Although the student-FWT dialogue may be enhanced by positive role modelling it may also generate issues which question both the level of the FWT's competence and her understanding and perception of professional knowledge. I would argue therefore that role modelling has serious implications for the process of reflection-in-action and the effectiveness of the practicum.

#### The level of student performance: the implications for the FWT

The final focus used to explore the conflicting demands of the practicum was the extent to which the FWT perceived the student's level of performance as a reflection of her teaching skill. The initial data used to explore this topic was obtained from the issue in the questionnaire which examined whether completing the

assessment procedure was stressful to the FWT. Although 7 (29%) of the cohort described the procedure as stressful, the dominant theme identified in causing stress was the student-FWT relationship. This particularly related to the intimacy of the relationship. There was no evidence that the stress was a result of concern about their teaching ability. However when this issue was pursued with the interviewees by asking whether it would worry them to fail a student, the majority expressed their concern and related this directly to their teaching skill. This is illustrated by comments such as "Yes- I would feel I had failed too - ". A similar finding was identified in the data generated from the discussions on their assessment of the student's performance being substantiated by another FWT. This was illustrated by a FWT saying " If the student was found not up to the mark in so many areas by another FWT I would feel I had failed to a certain amount because I hadn't picked it up or guided her'. In addition the data demonstrate the anxiety that was associated with the responsibility of failing a student. A very experienced FWT stated that she "wouldn't want to fail anyone just on my say so". The student-FWT relationship contributed to this anxiety. One FWT described the student as 'having so much at stake - her livelihood and all she's put into it and her family'. The issues identified in the situation of the borderline student also highlight the responsibility of the FWT. They described themselves working hard in those areas where the student needed more practice and one FWT actually described herself as being very tempted to get the student to the correct 'side' of the rating scale. The student-FWT relationship was identified as particularly important in the context of the borderline student although the FWTs considered it unfair to actually push the

student through. However, I would argue that the findings demonstrate that the FWTs perceive some correlation between the level of the student's performance and their teaching ability. This once more demonstrates the conflicting demands of the practicum, in particular the professional dilemma which is a consequence of the responsibility of providing the learning experience and assessing the student's competence in practice.

I would suggest the findings demonstrate the interdependence of the three roles of the FWT. Although some FWTs explicitly acknowledged the difficulty of being both teacher and assessor the majority of the cohort demonstrated the confusion between these two roles. The continued responsibility for a caseload determines a constant practitioner role. The FWT has to make decisions about her commitment to the student and her commitment to the caseload for which she is accountable. She has to decide how much time she can offer to the student. O'Shea and Parsons(1979) demonstrated that the availability of the teacher in the clinical setting was seen by students as the most important facilitative behaviour of teachers. The FWT must decide how she differentiates between her role as a counsellor and that of a facilitator and how she can distinguish between her teaching and assessing roles. Meisenhelder (1982) describes the emotional struggle experienced by clinical teachers in nurse education and a similar pattern is presented in fieldwork teaching. However the FWT has the additional responsibility of assessing the student's level of competence in practice and the ethical responsibility for maintaining professional standards and protecting the welfare of clients.

In addition the FWT is required to act as role model for the student. Lum (1978:142) suggests that the role model functions as a comparison reference group and is therefore fundamental in the professional socialisation process, providing the student with a framework for practice. Dotan et al (1986:55) describe a daunting list of attributes required in a role model and demonstrate that the personality of the role model is more important than the circumstances of the interaction. Rauen(1974) demonstrated the importance students placed on the clinical skills of the role model. While Smith (1977:42) describes the impediment to learning which results from conflict between the behaviour of the role model and their verbal instructions. The role model has particular implications for the student's appreciation of professional artistry in competent practice. However, in the current assessment procedure in health visiting the role model takes the major responsibility for assessing the student's performance.

Schon (1987) describes the attainment of an appreciation of professional artistry as a fundamental aim of the experience provided for the student in the practicum. The previous discussion demonstrates the conflicting demands made on the FWT who is responsible for the provision of the practicum. The extent to which the student attains the aim depends on the skills of the FWT, not only in demonstrating and providing learning experiences for the student but also in their ability to reflect-in-action and to facilitate this process in the student. The dialogue between the student and FWT plays an essential role in this process and the importance of the student-FWT relationship in establishing this dialogue has been clearly demonstrated. However, the FWT

must also, using appropriate criteria, assess the level of competence achieved by the student. These issues demonstrate the critical role the FWT plays in achieving an effective practicum and particularly highlights the importance of her understanding and interpretation of professional knowledge. It is this understanding of professional practice which influences the paradigm of practice presented to the student and therefore has implications for the process of assessment. It is the interpretation of professional knowledge and the evolving paradigms of practice which provide the focus in the following section.

The FWT's interpretation of professional knowledge and the paradigm of practice presented to the student

Since the concept of role modelling has been established as a fundamental component in the learning environment provided for the student, the interpretation of professional knowledge and the consequential paradigm of practice presented by the FWT has implications for the student's education and training and in turn the assessment of competence in practice. The frames of practice selected by the FWT therefore directly influence the practice of the student. Interestingly the question relating specifically to the FWT's interpretation of practice in the questionnaire had been interpreted in different ways by the FWT cohort, thus invalidating the comments for the purpose of data analysis. Unfortunately, this phenomenon had not been identified in either the pre-pilot or pilot questionnaire. However, in the following question which addressed the subject of other criteria used to assess professional practice, specific practice issues could be identified. The importance of record keeping was identified and

significantly this importance was reflected in data obtained from other sources in the questionnaire and interviews. I would suggest that this demonstrates the increasing emphasis placed on identifying and preventing the incidence of child abuse and thus provides an important focus in frame setting in practice. It is interesting that the other practice issues which were identified by more than one respondent related to the wider issues encompassed in professional knowledge and included attributes such as tact, discretion, sensitivity and the student's perception of the needs of clients. However, once more the concept of intuition was not specifically identified and perhaps supports the observation by Schon (1987 : 13) that terms such as intuition "serve not to open up inquiry but to close it off. They are held as 'junk categories' attaching names to phenomena that elude conventional strategies of exploration". In order to obtain sufficient detail on the interpretation of practice it was necessary to sift through the data to identify those areas of practice consistently identified. Chapman (1979) in her portrait of the role of the typical FWT identified the important features of practice as: working with children under 5, engendering relationships, listening, communicating and assessment of family needs and regular routine home visiting to families and children. Significantly, those health visiting skills identified by more than one practitioner in the interviewee cohort were: home visiting, the formation of relationships, communication and record keeping. The importance of Child Health Clinics was also identified from the stress placed by the FWTs on providing and assessing this experience. This presents a similar pattern to Chapman's study. This supports the view presented by the Community Nursing Review (DHSS 1986) that practitioners remain



trapped in a traditional approach to practice despite the publication of documents such as Project 2000 (UKCC 1986) which identifies the health visitor's responsibility in health promotion to all age groups. It also suggests that FWTs assume a restricted interpretation of professional knowledge which has implications for the adopted paradigm of practice and therefore, the students learning in the practicum.

The data provided by the discussion with the interviewees on the students' ability to handle a crisis in a family allocated to their workload was also used. In defining a crisis various factors were identified, however only non accidental injury was cited by more than one FWT. It is significant that several FWTs cited the clients' perception of a crisis as the only method of defining a crisis situation and this was identified as anything which was having a disturbing effect on the family or client. One FWT described it as "...how the family see it - if they think it's a crisis it's one - it could be 101 things..". This suggests a client centred approach to practice which influences the paradigm of practice presented to the student.

It was possible in the student assessment forms to identify features of practice which FWTs did not judge appropriate for the intermediate assessment procedure, thus suggesting those features were not considered essential in practice and therefore once more indicative of the adopted paradigm of practice. 15 (63%) of the cohort placed one to one teaching in this category, which suggests health education is not considered an important feature of practice. This is substantiated by Dunnell and Dobbs (1982:57) who found only 7% of the health visitors' time was described as

health education. Once more this has implications for the interpretation of practice presented to the student.

The issue of keeping up to date with professional developments was also used to analyse important features of practice. The interviewees were asked directly if they experienced difficulty in updating their professional knowledge. The majority acknowledged this as a major problem and related it directly to time constraints. Indeed, the student was often identified as a method of keeping the FWT up to date, which has serious implications for the effectiveness of the practicum, in particular the FWT-student dialogue. However, it was also possible to identify a theme demonstrating a reluctance in accepting new ideas in practice stating that they were often ideas for ideas sake. This was demonstrated specifically with the implementation of the health visiting process. The issue of the health visiting process was introduced as a method of establishing whether the FWTs were keeping up to date with current ideas in practice. Although only 3 (12%) of the respondents had actually implemented the process, the comments made by the cohort were illuminating in their interpretation of the process. The process was described as task based, providing a tool for planning, structuring, analysing, recording and evaluating home visits. It was considered time wasting and deficient in identifying clients' perception of their health needs.

However it is significant that the Statutory Instrument No. 873 (1983 : 13) specifically requires health visitors to be competent in '(a) co-ordination of skills in health assessment, identification of need, planning implementation and evaluation of

health education and care'. This once more highlights the discrepancy between the theory of practice and the reality of the practice setting. It is pertinent to note that a further 3 (12%) considered they were already "doing the process". This was illustrated by the comment "neither is it a new tool - in a modified form it is something I have always done and the way I have always worked". This feeling was substantiated by another FWT stating "we all do use the process". These comments support the argument presented by Clark(1985) that practitioners have misinterpreted the health visiting process in not perceiving the process as a method of developing a conceptual framework for practice. Indeed the role ambiguity experienced by health visitors is attributed to the lack of a single conceptual framework. This is illustrated by one FWT's comment "I don't think people ever know what health visiting is about until they've been doing it for a while". However I would argue that it is interesting that despite the criticisms identified in the use of the process highlighted in Chapter 4, the only FWTs confident in their methods used to assess the students' competence in assessing the health needs of clients were those who had effectively implemented a process approach to practice.

I would argue the data not only demonstrate the traditional paradigm of practice presented to the student in the practicum but also the implications of this interpretation of practice for student learning. Indeed the interpretation of professional knowledge will control the extent to which the student experiences a traditional or more innovative paradigm of practice. Schon (1987) argues that the effective practicum must reflect the professional knowledge explored in the college setting and the

experiences provided in the practicum must provide a central focus for debate and discussion in the college setting. I would argue that the data seriously question the effectiveness of the practicum and indeed whether a practicum is actually offered in student learning. It must also question the process of assessing the students' competence in practice since the interpretation of professional knowledge is limited to that required for an individual directive paradigm of practice. However, I would suggest that the paradigm of practice experienced by the student is also influenced by the learning opportunities provided by the caseload of the FWT and the practice policies of individual Health Authorities.

The learning opportunities provided for the student in the practicum

The FWT is responsible for providing the learning experience for the student in the practicum and although it is possible for the FWT to provide alternative experience in health visiting, the majority of the learning opportunities will be based on the actual caseload of the FWT. The variation in the practice settings provided for students has been recognised by the ENB in the production of guidelines for managers, FWTs and lecturers. When discussing the provision of learning opportunities the guidelines state that

"the FWT must cover a broad range of health visiting practice, provide opportunities for work in a variety of settings and encourage community participation in health education and care" (ENB 1986:3). However the caseload of the individual FWT may restrict these learning opportunities which in turn has

implications for the assessment process. It is therefore important to explore the extent to which the FWT's caseload fosters learning opportunities for the student.

The ENB describe the caseload as 'the population for which the health visitor has a designated responsibility' (ENB 1986:3). However the data demonstrate that the majority of FWTs describe their workload rather than caseload. Indeed only two of the 24 FWTs referred to their caseload in terms of population size. In one instance this was to state that the population size was actually unknown and the other stated she was working with a G.P. practice population of 10,000. It is interesting to note that this compares with an average H.V. population ratio of 1:5056 demonstrated in a study carried out in 1979 (Barrell-Davis and William 1984: 9) which is in turn significantly higher than the ratio of 1:4300 recommended by the Jameson Report (MOH 1956) and the DHSS in 1972 of 1:3000 population. Goodwin (1988) argues that a caseload of 1:2000 would be much more realistic. Although it is impossible to compare the findings in detail with national statistics, Table 6.8 demonstrates the range of workload size.

TABLE 6.8

Children under 5	FWT	Number of Families	FWT
201-160	3	100-160	3
261-320	2	161-220	6
321-380	5	221-280	3
381-440	0	281-340	2
441-500	1	341-400	2
	11		16

N = 24 (3 FWTs described their caseload using both classifications)

The Distribution of FWT Caseload/Workload size

Those in the higher bands obviously have implications for the effectiveness of the practicum. Schon (1987:37) describes the practicum as relatively free from pressures and distractions. However, I would suggest that the high workloads create considerable pressure and distraction for the FWT. Consequently the conflicting demands upon her time and demand for professional accountability severely limit the opportunity and the quality of the dialogue with the student.

When the cohort was asked to identify client groups within the caseload the concentration on the under five age group was marked. Only 4 (17%) identified the elderly as a client group. However when specifically asked if they considered their workload gave an adequate representation of health visiting practice only 8 (33%) described it as nonrepresentative. Although the majority related this to the lack of elderly clients, factors such as the lack of school work, a bias towards a particular social group and the lack of non-crisis health visiting intervention were also identified. It is significant that within the group who considered their practice as representative, only one described herself as working with the general population. These findings indicate that the FWTs concentrate their health visiting practice on families with young children and this finding is supported by other research which demonstrates that only 12% of the health visitors' time with clients is spent with those over 65 (Dunnell and Dobbs 1982:45). I would suggest that the data demonstrate not only a traditional paradigm of practice but also that a significant proportion of the

cohort acknowledge the limitations in the learning opportunities provided by their workload.

Another factor influencing the learning opportunities provided for the student is the practice situation of the FWT. This may be either in a G.P. attachment or on a geographical basis. Within the FWT cohort these figures were 50% and 42% respectively. The percentage of the sample working on a geographical basis is relatively high compared with other studies which demonstrated figures of 10% and 13% (Dunnell and Dobbs 1982: 11; Draper et al 1983:21). Although G.P. attachment has in the past been cited as a method of facilitating the work of the Primary Health Care Team (Hicks, 1976), this has been disputed by recent reports (DHSS 1986). Table 6.9 illustrates the different interpretations of this concept by FWTs which has implications for the learning opportunity provided for the student.

TABLE 6.9

Professional groups	Frequency
HV	17
School Nurse	11
District Nurse	10
GP	9
CPN	5
Clinic Nurse	2
Midwife	1
Speech Therapist	1
FP Nurse	1
Social Worker	1
Ophthalmologist	1
Child Guidance	1
Auxiliary	1

The frequency by which particular professional groups were cited by the Field Work Teachers as members of the Primary Health Care Team. (PHCT)

In addition it is significant that only 7 of the cohort were based in a practice situation which included more than 3 members

of the PHCT. Thomas et al (1985) argue that being based with other professionals does not necessarily facilitate good inter-professional relationships, however the lack of contact with other professionals in the practice setting must limit the learning opportunities available to the student to develop their skills in teamwork and I would suggest has implications for the quality of the student-FWT dialogue.

The lack of Child Health Clinics, the opportunity of working with different cultural groups and the inadequate representation of certain socio-economic groups were also identified as practice issues which influenced the learning opportunities of the workload. Dunnell and Dobbs (1982:45) demonstrated that 26% of the health visitors' time with clients was located in Child Health Clinics. However 6 (25%) of the student group were considered to have insufficient experience in running a Child Health Clinic to assess this skill in the final assessment procedure. The issue of providing the student with appropriate learning opportunities was explored further with the interviewees. When asked if they were able to provide alternative approaches to health visiting practice, significantly several of the FWTs required clarification of this concept. However the predominant theme in the analysis demonstrated the use made of colleagues in providing alternative approaches to practice. The experiences included within this concept were working in a geographical placement, working in a G.P. attachment, using the health visiting process, working with different socio-economic groups, working with specialist health visitors and working with colleagues with a different approach to practice. One FWT in an attempt to summarise her reason for selecting an alternative experience for the student said " ...she



did have a day in a different part of the health district-more the type of area she'll be working with-totally different types of families. It's so cosy here really - somehow we don't quite know how the other half of the world is.."

I would argue that the data demonstrate the influence of the caseload and in particular of the workload on the learning opportunities provided for the student. Indeed traditional practice priorities can be clearly identified. However it is significant that even within this practice setting the FWTs demonstrate the difficulty of providing satisfactory learning experiences and their reliance on colleagues to supplement student learning. This has implications not only for the quality of the practicum and the dialogue between the student and the teacher-practitioner (particularly where the practitioner has received no additional training in working with students) but also for the process of assessing the students' competence in practice. It also questions the extent to which the guidelines provided by the ENB are appropriate to practice and I would suggest demonstrates the discrepancy between the reality of the practice setting and the stated requirements for appropriate learning opportunities for the student. However Schon (1987:296) argues that the learning opportunity for the student is also affected by the student's ability and willingness to step into the practicum. I would suggest this is in part influenced by the personality of the student, an issue which has also been identified as influencing the process of assessment (Bradley 1984, Rushton & Murray 1985). This issue was therefore explored with the FWT cohort.

## The influence of the personal attributes of the student on the outcome of the assessment of competence in practice

The health visitor's ability to form effective relationships with clients is fundamental to professional practice. Robinson (1983) argues that caring about clients is an essential component of competent practice and Clark(1985) describes the nature of the professional-client interaction as the core of health visiting. Recent developments in health visiting demonstrate the current emphasis on practitioners of working in partnership with clients (DHSS 1986:61, HVA 1985:15, De'ath 1986:1). I would suggest that the practitioner's aptitude in forming effective working relationships is an essential factor in influencing the appreciation of professional artistry in health visiting and thus crucial for competence in practice. Although the student will need to develop skills to promote effective relationships with clients and colleagues, the personal attributes of the individual will also influence this process. Consequently the personal attributes of the student are pertinent to their professional development and indeed must be considered within the process of assessing competence in practice. However studies have also demonstrated that personal attributes affect the assessment of an individual's performance (Rushton & Murray 1985,Bradley 1984). Therefore because of the influence of the student's personality on both the learning experience and the assessment process, I considered the FWTs' perception of the effect of the student's personality on their assessment of the student's competence to practice an important focus for the data analysis.

The influence of the personality of the student in the process of

assessment was demonstrated in the questionnaire responses. When asked directly if the personality of the student influenced their assessment of the student's performance 19 (79%) of the sample replied positively. The predominant theme of the inevitability of this occurrence was identified by the use of terms such as 'bound to' and 'surely'. Some FWTs identified the direct link between personality and the procedure, by describing the implicit role of personality in the majority of the criteria in the structured assessment procedure. The interaction between personality, practice and assessment was also identified. An illustration is provided by the comment " I think it's bound to be influenced by personality just as personality affects practice". One FWT explored this concept further; '...however objective one aims to be, the fact that health visiting competence hinges on the ability to inter-relate with others at a satisfactory meaningful level must mean that a student's personality and behaviour have some degree of influence on such an assessment". Although the FWTs considered this influence inevitable concern about this phenomenon could be identified. The concern related to their feeling of lack of professionalism, of being judgemental and the issue of a personality clash. I would suggest these feelings demonstrate the ambivalence experienced by FWTs in accepting the fundamental role of personality in competent practice and is an issue which requires addressing in depth.

Mulholland (1973) described the characteristics of the 'good' health visitor and although she acknowledged the importance of knowledge and experience, the main emphasis was placed on the practitioner's personality. In this study 22 (92%) of the FWT cohort considered that personality influenced the student's

competence in practice. England (1986:40) presents a similar phenomenon in social work and argues it is impossible to make a 'division between the actor and his knowledge - (that) the knowledge is realised only by the worker'.

TABLE 6.10

Trait	Ranking
Sense of humour	1
Enthusiasm	2
Ability to form relationships	2
Adaptability	3
Open-mindedness	3
Empathy	3

Significant Personality Traits in Student Health Visitors

Table 6.10 demonstrates 6 of the most important traits identified by the FWTs and ranks them in order of frequency. Similar characteristics were identified in Mulholland's study. Only one FWT stated that personality did not affect the level of competence. she considered "...it was possible for all personality types to function well as health visitors so long as they remained objective". However the importance attached by clients to the personality of the practitioner is well documented (Orr 1980, Robinson 1982, Hennessy 1985). Indeed I would suggest that the extent to which the student develops an understanding and appreciation of the intuitive knowing in practice which informs

professional judgement in determining practice strategies, is directly influenced by personality factors.

Furthermore the effect of the student's personality on the process of assessment was identified in the data obtained from the semi-structured interviews. Not only was personality cited as a major cause for the difficulty in defining criteria for competence in practice, but it was also cited as influencing the objectivity of the assessor. Personality traits such as rigid and strong personal views, a clash of personality (which included the FWT not liking the student) and irritating mannerisms were identified as factors directly influencing objectivity. The FWTs acknowledged that the student's personality influenced whether they over or under estimated the student's performance. They also identified the difficulty of personality obscuring the actual level of knowledge. It is interesting that this concern particularly related to those students described as having an "ideal health visiting personality". The FWTs also identified personality traits as a factor influencing the student's ability to assess their own level of performance when working with clients. Traits such as detachment, confidence, caution, nervousness and sensitivity were identified and linked directly to the student's level of competence in practice.

The influence of other personal attributes on the process of assessment was revealed in the data. Although the FWTs did not consider their objectivity was influenced by the gender of the student, the prejudice towards male health visitors was clearly identified. This related particularly to a dislike of the presumed sexual orientation of the individual. Other prejudices

were also demonstrated with one FWT stating that she would feel more at ease with a male health visitor than a female West Indian health visitor. None of the interviewees had experienced working with a male student, but the evidence suggests that in some instances the processes in the assessment procedure would be influenced adversely. Certainly sex bias has been demonstrated in the assessment of students' written work (Bradley 1984). Some FWTs considered that the ethnic background of the student may influence the outcome of the assessment of the student's competence. In some instances this was related to the difficulty of selecting clients for the student's workload. One FWT described her feelings as being very cautious "...I mean that sounds awful - as to whom I'd send that person into - I just wouldn't want them to be hurt and I know in some instances they could be. I know I have some clients I definitely wouldn't send that person to...". Other FWTs stated that they honestly could not say how it would affect the objectivity of the process until they had experienced the situation. Of those FWTs in the interview sample only one was black and only one was working with a black student. This FWT did not consider the objectivity of the process had been influenced by the student's ethnic background. However the student's overt unhappiness in the fieldwork placement had created difficulties for the FWT. Indeed she considered that the student had expressed her feelings of unhappiness by being very defensive. Although the FWT stated she could "sort out her (the student's) practice and her (the student's) defensiveness- I know she's improved quite a lot but it's coloured my attitude". I would suggest this demonstrates the prejudices which can exist where the quality of the dialogue between the FWT and student is poor. This obviously has

implications for the student's learning opportunities and consequently the process of assessing competence in practice.

The age of the student was not considered a significant factor in affecting the objectivity of the assessment process, although some interviewees stated that their lack of experience working with different age groups made it difficult for them to answer. However the older student was identified as a cause for concern to some of the group, although one FWT stated that she was pleased she had worked with a mature student as she felt younger students tended to be more critical and she felt "safer" with an older student.

I would suggest this once again raises the issue of the quality of the student-FWT dialogue and questions the extent to which some FWTs feel confident in reflecting on their practice. However, there was no correlation between the age of the FWT and the feelings they expressed about the age of the student. Although the socio-economic background of the student was not considered significant to the objectivity of the assessment process, the political views and appearance of the student were identified as influential factors. One FWT found "it difficult to deal with somebody in the jeans brigade". Another FWT stated "with all these things it really depends how it affects them as a person....if that affected their personality and then their health visiting practice I suppose that would make a difference in some sort of way".

I would argue that the data demonstrate the importance of the student's personality in the assessment process in two specific

contexts: the role of personality in competent practice and the effect of personality in influencing the assessment procedure. All but one of the FWTs acknowledged that personality influenced the competence of the practitioner, which contributed to the difficulty of understanding and interpreting professional knowledge. However the student's personality was also identified in influencing the objectivity of the assessment process, particularly those students with the 'ideal health visiting' type. It is significant that the FWTs expressed greater concern about the level of the student's knowledge than satisfaction that the student demonstrated the potential for an appreciation of professional artistry. I would suggest this supports the argument proposed earlier in the chapter that professionals negate those areas of practice perceived as 'junk categories'. The findings also demonstrate the prejudices identified in some FWTs, not only against relatively minor issues such as mode of dress but also against major issues such as race and gender. Indeed I would argue that there are serious implications for the practicum offered to the student, not only in the provision of learning opportunities but also in the student-FWT dialogue. Where the dialogue is hindered by a poor student-FWT relationship this may result in a learning bind which may not only affect the student's ability to grasp concepts of practice but also influence the process of assessment. Therefore, I would argue that the personality not only of the student but also of the FWT needs to be given consideration if an effective practicum is to be developed.

### Conclusions

The FWT has the responsibility for the provision of the practicum



in health visiting education and I would argue that the data demonstrate three specific factors which not only influence the effectiveness of the learning environment but also the process of assessing the student's competence in practice. The first is the FWT's understanding of the nature of professional knowledge and the implications for professional competence; the second is the actual experience provided for the student in the practicum and the third is the influence of the individual FWT on the quality of the student-FWT dialogue.

The FWT's interpretation of professional knowledge is illustrated in the range of professional expertise constituting health visiting practice. However, in exploring the different frameworks from which professional practice is defined, the influence of the personality of the practitioner, particularly in establishing effective client-practitioner relationships is also identified. Indeed the fundamental role of those factors influencing the practitioner's understanding and appreciation of professional artistry has been clearly identified in competent practice (Schon 1987, England 1986). Although the assessment procedure provided the FWTs with defined boundaries on which to base their assessment of the student's skills in practice, it does not facilitate the assessment of those areas of professional practice included within the concept of professional artistry. The dependence placed by FWTs on informal methods of assessing the student's competence to practice reinforces this finding. In addition the assessment procedure does not facilitate the crucial processes required by FWT in judging the level of performance demonstrated by the student, nor indeed in identifying the processes involved in reflection-in-practice, particularly critical in the assessment of

competence in practice. I would argue that it is significant that concern about these issues cannot be identified within the data which demonstrates the restricted interpretation of the nature of professional knowledge by a significant proportions of the FWT cohort.

This finding is reflected in the experience provided for the student in the practicum. The data illustrate the traditional paradigm of practice demonstrated by the majority of FWTs. The interpretation of practice frequently does not reflect the philosophy of a proactive approach to health promotion advocated in practice policy documents nor indeed the competencies required by the Statutory Instrument. This has implications for competence in practice, particularly when taking into account the fact that a significant proportion of the FWT interview cohort perceived themselves as a role model for the student and therefore a critical influence on the process of professional socialisation. It questions the extent to which the practicum gives the students opportunity to reflect on and practice different interpretations of practice. In addition it questions whether the student's learning in the practicum runs in parallel with that in the theoretical component. Where discrepancy exists this seriously questions the effectiveness of the practicum, both in the provision of learning in professional practice and in assessing the student's competence in practice.

The influence of the individual FWT in the practicum is the third specific factor identified in the data. Schon (1987) describes a particular task of the coach as building a relationship conducive to learning. I would argue the student-FWT relationship presents

a central focus to the data. The FWT's perception of the quality of the student-FWT dialogue is influenced by the student-FWT relationship and this is particularly pertinent to the student developing the ability to reflect-in-action. However, the significance of the FWT-student relationship is equally identified within the assessment process. This I would argue has implications in the assessment of competence in practice particularly since the data demonstrate that a significant proportion of the FWTs experienced conflict in synthesising the roles of teacher, assessor and practitioner. I would argue in addition this raises the question of the extent to which the assessment procedure facilitates the FWT in assessing practice in which she has actively coached the student.

Schon (1987) argues that although the practicum is designed to enable the student to learn a professional practice, the individual interpretation of the practicum is influenced by the practitioner's view of the kinds of knowing essential to professional competence. I would argue that the practicum perceived by the majority of the FWTs demonstrates an approach of technical training, therefore adopting an apprenticeship model, rather than one which enables the student to learn the forms of inquiry by which practitioners adapt their professional knowledge to each unique practice setting. It is significant that despite the FWTs recognising the importance of an appreciation of professional artistry in practice, this concept is negated in the process of assessment and illustrates the contradictory relationship between the nature of professional knowledge and the process of assessment. I would suggest these issues have implications for the student's interpretation of professional

knowledge and consequently the assessment of her competence in practice and therefore require addressing in the student cohort.

- (1) Following the introduction of fieldwork experience the practitioners responsible for this component of the students' training were called Fieldwork Instructors. However the name was changed to Fieldwork Teacher in 1972 in an attempt to emphasise the educative role of the practitioner. (CETHV 1975b)

## CHAPTER 7

### The Practicum: the student's interpretation of professional practice and the implications for assessing professional competence.

The health visitor student enters the practicum as a qualified practitioner with an extensive range of professional and personal experience. However, during her time in the practicum, the student will not only be exposed to an array of new concepts and professional knowledge, but also to a new range of professional practices. Indeed the curriculum has been generally criticised by the profession for being overfull and subjecting students to intense learning over a relatively short period of time (NSC 1980). Although the acquisition of new knowledge and previous experience will influence the student's interpretation of professional knowledge, Schon (1987) argues that there are three specific factors which are equally significant in influencing the student's understanding and interpretation of professional practice: the process of socialisation, the influence of the practicum and the predisposition of the individual student.

The process of socialisation has been described as the initiation of the student "into the traditions of a community of practitioners and the practice world they inhabit" (Schon 1987 : 36). It is within this practice world that the language, conventions, appreciative systems and patterns-in-knowing, developed and perpetuated by

practitioners, provide the foundation for the socialisation of the student. Indeed it is within this process that students acquire the set of values and understanding to make sense of practice situations and determine the features of appropriate professional practice. In health visiting education although the student will come into contact with different practitioners, it is implicit within the current framework of education and training, that the FWT plays a major role in the student's process of socialisation. However it is significant that While (1981) describes a number of students' criticisms of their FWT and argues the need to provide students with a greater choice in role models. A similar finding is presented by Bergstrand (1985) who argues that the practitioners working with the student at the time of qualification are equally influential in the student's socialisation process. Dingwall (1977) argues that the predominant concern of the students while in training is "getting through" the course and in particular the written assessment procedures. This I would suggest calls into question the extent to which the students are overtly aware of the socialisation process. This has far reaching implications as regards the understanding of professional knowledge and in particular the interpretation of professional practice.

The previous two chapters have highlighted the factors influencing the assessors understanding and interpretation of professional practice. The fundamental effect of this interpretation upon the learning experiences provided in the practicum has also been identified. It is therefore equally

pertinent to analyse the influence of the practicum on the students' understanding of professional knowledge and interpretation of professional practice. Indeed it is the practicum which provides the student with the opportunity of exploring the kinds of knowing which are appropriate to professional practice. However, Turner (1982 : 282) argues that the evidence from a very small pilot study of five health visitors, demonstrated that "well over half of these particular health visitors' skills and knowledge in dealing with basic routine health visiting topics was acquired on the job and not during health visitor training". Although Schon (1987) argues that the practicum must include the essential features of practice and represent the reality of the practice world, the discussion in Chapter 1 demonstrates the inappropriateness of adopting such a task-based approach to the interpretation of professional knowledge (as was suggested by those practitioners in the survey described above). Indeed I would argue that evidence such as this, highlights the vital role the practicum plays in facilitating the student's ability to develop an epistemology of practice grounded in reflection-in-action.

However the students' ability to achieve an understanding and interpretation of professional practice which is appropriate to the individual practice setting will depend not only on factors identified above but also on the style of coaching offered by the FWT, and in particular in the quality of the student-FWT dialogue. Indeed I would argue that the quality of the dialogue is dependent on the style of coaching offered to the student. In an effective practicum it is essential

that the coach (in this case the FWT) resists the temptation to tell the student how to solve the problem or which practice strategy to adopt. Instead it requires a variety of solutions or strategies to be offered to the student so that she has the opportunity to freely choose the strategy or develop new strategies appropriate to the practice setting. In addition the effectiveness of the practicum will be influenced by the opportunity for the student to learn by doing, the interaction with her peer group and the process of "background learning". These factors highlight the need for the theoretical component and the practicum to develop in tandem, rather than as two distinct entities.

Nevertheless, the understanding and interpretation of professional knowledge will also be influenced by the individual student. Schon (1987) argues that a student on entering the practicum is presented, often implicitly, with specific tasks to achieve if the learning experience is to be effective. These tasks require the student not only to recognise competence in practice, but also to appreciate her own development in relation to the competences in practice she wants to acquire and how this can be achieved. In addition she must recognise the implicit items of the practice: "that a practice exists, (is) worth learning, learnable by her and represented in its essential features in the practicum" (Schon 1987 : 38). However the student must also be prepared to commit herself to 'stepping into' the practicum if she is going to benefit completely from the learning experience. Schon (1987 : 166) argues that this commitment creates feelings of loss including: loss of



control, competence and confidence. This in turn creates feelings of vulnerability which may be demonstrated in the student by overt defensiveness. The difficulties experienced by students in adapting to the student environment in health visiting has been well described (Robertson 1982, Everett 1981, Dingwall 1977). For many students this is their first experience of education outside the highly constrained environment of school or a school of nursing. The feeling of loss may be particularly exacerbated by the process whereby the practitioner once more assumes student status despite paradoxically being required to resume the practitioner role in the learning experience. It is the presence of these phenomena in the practice situation which once more illustrates the importance of the student's interaction with those factors influencing the effectiveness of the practicum. This interaction is demonstrated in Figure 7.1.

I would suggest these factors play an essential role in the student's understanding of professional knowledge and interpretation of professional practice which in turn will affect the students' perception of the process of assessing their professional competence in practice. These factors raise issues which provide a framework for the data analysis acquired from the student assessment procedures, the questionnaires and the semi-structured interviews completed by the student cohort. These are:

- i) the students' interpretation of professional knowledge in relation to the process of assessment,
- ii) the students' perception of the conflicting demands of the practicum,

## Factors influencing the effectiveness of the practicum and the assessment of competence in practice.

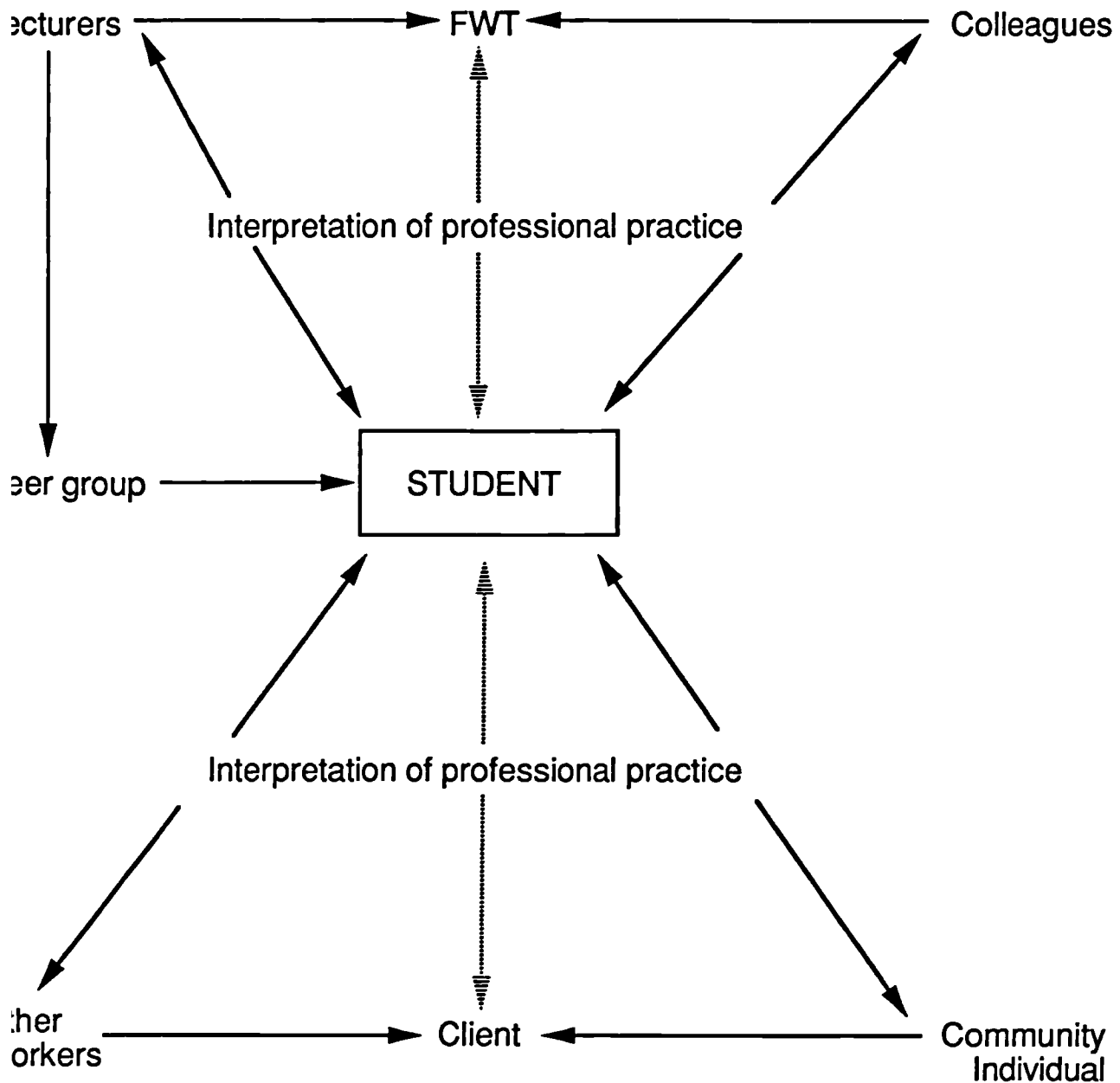


Figure 7.1.

- iii) the conflicting paradigms of practice presented in the practicum,
- iv) the students' perception of the effectiveness of the practicum,
- v) the influence of the FWT on the process of assessing competence in practice. These issues will be considered sequentially to explore the students' interpretation of the professional practice presented in the practicum and the implications for assessing competence in practice.

1) The students' interpretation of professional knowledge in relation to the assessment process

The interest demonstrated by the FWTs and lecturers in the understanding and interpretation of professional knowledge and the assessment process was reflected in the student cohort. 26 of the 27 students involved in the study returned the confidential questionnaire (Appendix J) providing a 96% response rate. Of the 13 students selected for the semi-structured interview, only one student did not wish to participate. Although I felt unable to pursue her refusal because of my dual role of lecturer and researcher, I feel it is significant that this student was the only representative from an ethnic minority group and had experienced considerable difficulties in her fieldwork placement. These factors may have influenced her perception of the assessment process and provided a valuable source of data.

Although the students are presented with a prescribed

analysis of professional practice in the formal assessment procedures, the influence of the student's own understanding of professional knowledge or that of the FWT cannot be ignored when considering the student's interpretation of professional practice. Indeed, Schon (1987) describes the influence of the coach and in particular the student-coach dialogue in the student's understanding of professional practice. Therefore the initial stage in the data analysis was to explore the students' perception of their relationship with their FWT. The phenomenon of the FWTs' dual role of assessor and teacher was used to explore this relationship. However 19 (73%) of the cohort described their relationship as unaffected by this issue and in some instances the student did not actually perceive the FWT as an assessor. This is illustrated by the comment:

"I don't think of my FWT as an assessor...we have a good relationship and I find her easy to talk to and ask for help. I trust her and I'm sure she is fair minded. I know she is concerned that I should do well and qualify and that she will give me as much guidance as she can". Another student although confirming this feeling, described the FWT as having an incentive in providing help to the students, as poor quality work would be seen as a direct reflection of her teaching skills. However the predominant theme related to the quality of the relationship which was described as being "good, sensible, friendly and understanding". Indeed the significance of the effect of the personality of both the student and FWT on the relationship was identified and this issue is explored in depth later in the Chapter. It is

interesting that only one student identified the possibility of difficulties arising if the FWT and student experienced a personality clash.

The importance the students placed on this relationship was marked. It is also pertinent to note that despite one student continually feeling that her work was being assessed, she did not consider this had affected the relationship with the FWT. I would suggest this relates directly to the respect this student expressed for the professional practice of her FWT. Jarvis and Gibson (1985 : 15) argue that "the authority of the teacher practitioner resides entirely in the recognition of her professionalism". However, of those 7 (26%) students who stated that their relationship had been affected, the influence on the student's behaviour is demonstrated. An example is given by the student who described her reluctance in admitting to her FWT any weakness in her performance. This I would suggest not only reflects the quality of the student-FWT dialogue but also has implications for the students' interpretation of professional knowledge as self-assessment is essential in the process of reflection-in-action.

The significance of the FWT-student relationship could also be identified when exploring with the students, whether the assessment process had been a stressful experience. The predominant theme of those 19 (73%) respondents who had not found the process stressful, related to the fact that the procedure held no surprises for them. This had been achieved by the continuous assessment of their progress so that they

considered they would be aware of any comments which would be made about their performance. Feelings such as fairness and honesty emerged. However one student described feelings of embarrassment rather than stress. This was attributed to the fact that the process was completed jointly with the FWT and she appeared hesitant in her comments. This once more reflects the importance of the quality of the dialogue and in particular the ability of the FWT to reflect on practice. However, the significance of the student-FWT relationship was equally apparent with those respondents who had experienced the process as stressful. One student stated that "it would totally destroy the teaching value and relationship if my FWT were to criticise my ability...", thereby demonstrating the conflict experienced by students in receiving criticism from their FWT. I would argue that it is also significant that when the issue of stress was pursued with the interviewees, the only student who consistently described feelings of stress during the assessment process related this to the hidden agenda of the process. She was concerned that the FWT would find some aspect of her practice unacceptable which she had previously been unable to share with the student. However, it is significant that 3 (25%) students were overtly critical of their FWT for failing to offer constructive criticism. This observation is particularly pertinent as this is an area of fieldwork teaching in which participants in the FWT cohort admitted they experienced specific difficulty (Chapter 6 :203).

Therefore I would argue that the data demonstrate the importance that students place on the FWT-student

relationship, which in turn raises questions about the implications of that relationship for the interpretation of professional practice. However the students' overt criticism of the FWTs' ability to offer constructive criticism, calls into question the extent to which the FWT effectively fulfils her role in the practicum. I would argue the data also demonstrate the importance of the quality of the FWT-student dialogue, again a fundamental issue in exploring the interpretation of professional practice. If the relationship, or indeed the quality of the dialogue is poor, the student will be exposed to a learning experience which resembles that of technical training in the practice setting, as described in Chapter 6. This I would suggest inhibits the student's ability to develop expertise in those practice issues essential to the development of an appreciation of professional artistry. This in turn restricts the interpretation of professional knowledge which has implications not only for the interpretation of practice but also for the assessment process.

#### The students' perception of the assessment process

Having established the significance of the student-FWT relationship the next stage of the analysis was to establish the students' perception of the assessment process in relation to their interpretation of professional knowledge. It is interesting that although Dingwall (1977) describes the stress experienced by students in negotiating their written assignments, a different pattern emerged in the student cohort. The assessment process was predominantly identified as a method of diagnosing their strengths and weaknesses in

professional practice so that opportunities for improving practice could be provided. It was also described as a means of providing the student with general encouragement. The process was also identified specifically as a diagnostic tool for the college lecturers, so that any special help or omission in the learning experience could be identified. However, 7 (27%) of the cohort did describe the purpose as assessing their competence in practice. This was expressed both in terms of the level of practice and the qualities required by the practitioner. One student described it "as seeing if one is capable of actually 'doing' the job". Another was more specific in her description of the process and identified four specific categories: "to examine my personality and relationships, to see whether I am adjusting well to my new role, to see whether I am suitable for the job as a health visitor, to evaluate my progress". It is significant that this student included her personality and the concept of relationship, both practice issues which contribute specifically to the development of an appreciation of professional artistry.

Another important issue to emerge was the students' perception of the value attributed to the procedure. One student described it "...as valueless unless the student is below standard". The lecturing staff were considered "uninterested in the process unless the student received a poor assessment". The students' perception of the value attributed to the process was explored further by asking in the semi-structured interviews if they had found the experience tiresome. This word was once more specifically



selected (Chapter 6:181). 6 (50%) of the cohort stated that although it was not tiresome they had not found it particularly helpful either. The procedure was described as an inevitable part of the course. The procedure was also not considered particularly important although this was acknowledged that this was an inappropriate reaction. One described her feelings saying "...this was half an hour which to us was at the end of the day when we would rather have liked to have got off home...it's not the way to approach that sort of assessment". Table 7.1 demonstrates the interviewees' perception of the time taken to complete the assessment process.

Table 7.1

<u>Students</u>	<u>Time in minutes</u>
28	15
14	not asked
10	20
16	10
8 (RM)	whole afternoon
18 (RM)	60
3 (RM)	60
23	45
21 (RM)	not asked
25	40
12 (RM)	30
19 (RM)	150

f = FWT perceived as role model by the student

Students' perception of the time taken by their FWT in completing the formal process of assessing competence in practice.

I would argue that it is significant that a correlation could be identified between the students' perception of the usefulness of the process and the time taken to complete the procedure. I would argue this demonstrates the students' perception of the quality of the student-FWT dialogue, particularly as those students identifying their FWT as a role model generally perceived the procedure taking significantly longer.

Nonetheless the data revealed that the majority of the student cohort described the process as useful, with the dominant theme being one of providing a framework for exploring practice. This evidence suggests that the students identified a relationship between the assessment process and the interpretation of professional practice. However 10 (38%) stated specifically they had not experienced the process as useful. This experience related to three specific issues: they already knew their strengths and weaknesses in practice, it did not reflect a true picture of their ability in practice and had their performance been inadequate this would have previously been identified by the FWT. The interviews provided the opportunity of exploring this issue in greater depth with students who were almost at the end of their course. 3 of the 12 had maintained their negative feelings about the procedure. The ineffective criticism by the FWT once more emerged, illustrated by the comment "...it's nice to have a nice assessment...I don't know whether it is meaningful... it's the things that are bad about you which are meaningful". This is illustrated further by the observation that the FWTs were too kind and were not always honest enough in their assessment, thereby supporting the findings presented in Chapter 5. Another student ascribed the lack of value of the procedure to the need for students

to undertake self-assessment. Indeed, the methods used by the FWT in the completion of the assessment procedure directly related to whether the student had found the experience useful. It is interesting that those students who had been jointly involved in the process were much more positive in their comments. Their involvement ranged from completing the form independently and then comparing results to actually completing it together. Those students who had carried out self-assessment expressed their surprise that their perception of their performance was similar to that of the FWT, an issue which is discussed in greater depth later in the chapter. The student who was unable to discuss her assessment with her FWT related this specifically to the effect of personality stating "it's because of the personality of my FWT - she's got such preconceptions, she's not open enough to new ideas...". These findings in addition to identifying the difference in perception of the assessment process between the student and the FWT cohort, once more highlight the importance of the student-FWT dialogue. The findings also raise the question as to the extent to which the dialogue currently facilitates the understanding and interpretation of professional knowledge. I would suggest that this not only has serious implications for the student's interpretation of professional practice but also for the process of assessing competence in practice.

The relationship between the assessment process and the interpretation of professional knowledge is also illustrated when the students were asked if they considered any modifications were required in the assessment procedure. Although 7 (27%) considered themselves too inexperienced in the use of the procedure to comment, other respondents raised the issue of the ambiguity in the criteria

selected for assessing professional competence. It is particularly significant that some students considered the criteria inappropriate for certain fieldwork placements, despite the fact that a skills approach to health visiting practice had been adopted in the design of the procedure. I would suggest this not only reflects the task orientated approach to the interpretation of professional practice adopted by some students but also the limited interpretation of professional knowledge, particularly in relation to an understanding of the concept of professional artistry.

The interpretation of professional knowledge could also be identified during the student interviews, when they were asked to describe the methods used by their FWT when assessing their ability to assess the health visiting needs of clients. Discussion with the FWT, the use of client records, listening to interview technique and the use of client feedback were the methods which the students identified. It is interesting that the health visiting process was identified as an important method of improving the effectiveness of this aspect of practice. Indeed the students described the process as a method of considering the principles involved in health visiting intervention, rather than the task orientated approach which occurred when only discussing the advice that had been offered. However I would suggest it is pertinent to note that the students did not perceive the use of a problem solving approach to practice as restricting the interpretation of professional knowledge.

Another significant feature to emerge was the home visiting pattern experienced by the student. One student had been visiting clients alone for the majority of the course and quite rightly expressed her concern at the lack of FWT involvement. Undoubtedly findings such as

these raise questions about the effectiveness of the practicum provided for the student. However others found it difficult visiting with their FWT as they considered this changed their relationship with the client. I would argue that this issue not only raises the question as to the extent to which students are given the opportunity to develop the ability to reflect-in-action (an essential requirement for the competent practitioner), but also once more identifies the issue of the quality of the student-FWT dialogue. Indeed I would argue that regular contact with the student in the practice setting is essential if the FWT is to assess an interpretation of professional knowledge which encompasses these practice issues essential to an appreciation of professional artistry. These observations are supported by one student, who when expressing her dilemma about the extent to which FWTs relied on student feedback in the assessment process, said "I can't see how else she could do it but I suppose I could say one thing and do another but one's got no way of knowing that - other than being with me all the time or getting feedback from clients I don't really see how she can be sure (what) I'm putting into practice". However this observation raises another issue in the relationship between the interpretation of professional knowledge and the assessment process: the use of self-assessment. Self-assessment forms an essential stage in the process of reflection-in-action and therefore the student's perception of the use of self-assessment provided a further focus to the data analysis.

However only 7 (27%) of the respondents stated that they would find self-assessment a useful method of assessing competence in practice and they particularly related its use to their own self awareness. They considered they knew their own inadequacies but required help

and guidance to improve them. It is significant however that the issue of home visiting alone was identified as a particularly important reason for introducing the concept of self assessment. Indeed they considered this would be an "honest and fair appraisal". Shepherd and Hammond (1984:83) demonstrated that medical students could significantly rate their own interviewing technique in the area of specific interpersonal skills. As previously discussed three respondents in the present study had actually experienced the process during the formative assessment and two had described it as a very useful experience. It is significant that one of these respondents stated that she had considered the process too complex until she had actually experienced self-assessment. Indeed she described the ratings of her own performance correlating with those of her FWT 99% of the time. This differs from the findings of Wheeler and Knoop (1982) who demonstrated that student-teachers over rate their own performance. Although other students within the student cohort identified the need for individuals to be self critical and objective to undertake self-assessment, concern about the emotional damage produced by self-assessment was also identified. However only 5 (19%) of the respondents did not consider the process useful and this was related to the effect of personality; either the student not being truthful, or too modest or embarrassed to make the process feasible. It is interesting that those students who did not consider self-assessment a useful procedure related this to factors which I would argue influence the process of self-assessment rather than the principle of the procedure. Indeed the confusion experienced by the students about the process is illustrated in the comment from a student, who despite actually participating in the process, commented "it would be extremely difficult as I don't think a student is the best person to do a self-assessment". Their understanding of the

process was therefore pursued in the semi-structured interviews.

The data revealed that some students related the procedure specifically to evaluating the health visiting intervention they had offered to a client rather than an appraisal of their own performance. This is illustrated by one student's comment "I think it's difficult because you've got to look at the way you're practising and your records and I haven't got all that sorted out yet - probably if you asked me in a year's time I'd have more ideas". However all agreed that self-assessment was important for their professional development. The effect of personality was identified as a significant factor in influencing the student's ability and willingness to participate in the process. One student described this as "...if you're writing on a form that you know is going to be seen by someone who is potentially examining you - you're not going to write something that is blatantly terrible or I wouldn't..." Other students specifically used the term personality and others identified traits such as confidence and honesty. However the students continued to identify the complexity of the task. Indeed the need for help and training required to undertake the process was articulated and they related this specifically to the need for objectivity and self-criticism for the process to be effective. It is interesting that in the student assessment forms only one student had attempted any form of self-assessment of her strengths and weaknesses. However in the questionnaire this student had considered herself too modest and embarrassed to participate in the process. Although this illustrates once more the confusion experienced by the students as regards the process of self-assessment, I would argue that the findings demonstrate that the students perceive the process of self-assessment as an integral part of professional practice, and

essential to their professional development.

Therefore I would argue that the findings demonstrate that the student's understanding of professional knowledge is not only dependent on their individual interpretation of the concept but also on the assessment process and the interpretation promoted by the FWT. The findings also demonstrate the importance students attach to their relationship with the FWT and in particular to the quality of the student-FWT dialogue. Although the quality of the relationship is affected by both the FWT's personality and her level of professional practice, it is interesting that students place considerable emphasis for the success of the relationship on the ability of the FWT to offer constructive criticism in an appropriate manner. This supports the theory of the practicum provided by Schon (1987), and indeed highlights the need for the FWT to demonstrate the ability to travel the ladder of reflection with the student so that reciprocal reflection-in-action may be achieved. Although the assessment procedure was predominantly seen as a diagnostic tool I would suggest it is significant that those students who described it as a method of assessing their professional competence included practice issues which specifically contribute to an appreciation of the concept of professional artistry. However I would also suggest it is significant that some students in part considered their performance a direct reflection of the teaching skills of the FWT, despite their negative comments about the expertise of the FWT in completing the procedure.

Although the findings highlighted the emphasis placed by some students on a task orientated interpretation of professional practice, the importance attached to issues such as self-assessment



illustrates the wider interpretation of professional knowledge identified by a proportion of the student cohort.

Nonetheless although the data highlight the student-FWT dialogue and the interpretation of professional knowledge demonstrated by the FWT as influential in the students' interpretation of professional practice, which implicitly has implications for the process of professional socialisation, I would argue that this process will also be affected by the students' willingness and commitment to enter into the experience of the practicum, particularly in relation to assuming a student role. The conflicting demands this creates for the student provides the focus for the following analysis of data.

i) The students' perception of the conflicting demands of the practicum

It is implicit that the practice the student experiences during the practicum encompasses the traditions and practice world of the practitioner. However students entering the practicum in health visiting, generally have not only achieved a wide range of personal and professional experience but also established their own professional role. This I would suggest not only exacerbates the feelings of loss and vulnerability described by Schon (1987) but also creates conflicting demands for the student. The students, the majority of whom have come directly from a clinical nurse background, are expected within the year to adjust to working in the community, predominantly in clients' homes and adjust from a well defined role to a more nebulous role. They are also required to not only adjust from working in an established hierarchy to working with considerable professional freedom but also to adjust from a practical to a facilitating role. The students may also have to adapt their personal roles. Everett (1981) describes the experience of coming

to terms with being treated as an adult while having student status. While (1981) describes the pressures and stress experienced by students during the course and their high expectations of the college experience. The majority of students in health visiting are married women (ENB 1985 :xx), which may impose additional stress upon individuals in adjusting to new demands and changes in their family life. Yogev (1982:169) argues that although women do not always recognise the demands of combining a professional role with that of a partner and a mother, these pressures have serious implications for the family as well as career development. Indeed all the student cohort were female and 8 (31%) had dependent children. The student is also required to adopt two new reference groups while undertaking the course: the student group and the new professional group. Lum (1978) argues that this socialisation process in itself may generate stress for some individuals. I would suggest these factors create conflicting demands for the student while in the practicum and this issue needed to be taken into account in the framework for data analysis.

As previously described Schon (1987) argues that the extent to which the student benefits from the practicum is influenced by the student's willingness and ability to "step into the practicum". However I would suggest this process is influenced by the students' professional background and their perception of the new reference group, both in terms of interpretation of professional knowledge and the individual FWT.

Table 7.2

years	n	%
2-4	10	38
5-7	8	31
8-10	1	4
11-13	2	8
14-18	0	0
19-23	5	19
N	26	100

The number of years since qualifying as an RGN

Table 7.2 demonstrates the amount of post initial registration experience obtained by the cohort before commencing the course. 10 (38%) had four or less years experience, demonstrating that the time spent practising as a qualified practitioner was relatively limited, which I would suggest may have implications for the perception of their professional role. Indeed 18 (69%) had been qualified for less than seven years, suggesting that the student cohort had less practitioner experience than the norm for health visitor students (McClymott 1980:41). This may reflect the location of the case-study college. Being situated in Greater London, it has a high proportion of students seconded or sponsored from inner city health authorities, which generally have a predominantly young mobile staff. However of the remaining 8 (31%) a significant proportion of the respondents had had a break in their career while child rearing. This may also have influenced the extent to which they had established a professional role prior to the course. Indeed these factors may have lessened the feeling of loss and vulnerability experienced by the student during the practicum, thereby allowing them to adapt to the practicum more readily.

The students' perception of the new reference group may also be influenced by their professional experience prior to starting the course.

Table 7.3

Occupation	n	%
unemployed	0	0
school/clinic nurse	4	15
district nurse	1	4
domiciliary midwife	1	4
hospital midwife	8	31
sister/staff nurse (H)	8	31
family planning nurse	2	8
other	2	8
N	26	100

Occupation prior to starting in the Health Visitor Course

Table 7.3 demonstrates that 16 (62%) of the cohort had no previous experience of working in the community. This compares with 391 (37%) of the 1057 health visitors in a study carried out by Dunnell and Dobbs (1982: 9). Although the lack of community experience prevents individual students entering the course with preconceived ideas of the interpretation of professional practice I would suggest it may influence the extent to which the students adapt to a practicum grounded in a community setting. Table 7.4 demonstrates that the majority of the student cohort had a midwifery qualification.

Table 7.4

qualification	n	%
RM	16	62
obstetrics	11	42
RSCN	2	8
DN	1	4
FP Cert	3	12
other relevant	2	8

NOTE: some respondents had more than 1 additional qualification

Nursing qualifications obtained in addition to RGN prior to starting the Health Visitor Course

Although this may reflect the unwillingness of some Health Authorities to select for training those students who need to complete an obstetric training (HVJC 1984:4) I would suggest this also indicates the students' traditional interpretation of professional practice based in an arena of maternal and infant health.

However I would argue that the interpretation of professional practice may also create conflicting demands for the student during their experience in the practicum. The discrepancy between the interpretations of professional practice made by lecturers in health visiting and those made by practitioners has been highlighted in the data analysis; a finding which is substantiated by other authors. (HV editorial 1981). McClymott (1980) describes students having to adapt their interpretation of practice on qualification and While (1981:152) describes the relationship between the theory and practice

as "an ever present problem". This issue was therefore identified as an important focus for the semi-structured interviews. It is interesting that although the interviews took place in the final stages of the course, none of the students considered the content of the theoretical component inappropriate. My position as a lecturer may have influenced their responses, however the students appeared definite and confident during the interviews. However the predominant theme in the analysis was the existence of some incongruity between theory and fieldwork. It is significant that the students related this specifically to the area in which the FWT practised, rather than the FWT's individual interpretation of professional practice. Hunkins (1985) argues that not being able to practice that taught in theory is a source of anxiety for the students. Although one student described her frustration at the bias towards crisis work in the practicum and her pleasure at the consistency between theory and practice in her alternative fieldwork placement, (1) student anxiety could not be identified in the data. However, students considered it inevitable that the theoretical component taught the ideal and considered this appropriate, stating that it was the only way of learning what could be attained in practice. One student demonstrated a degree of anger towards the lecturers' interpretation of practice, which related to her perceptions of their limited understanding of the influence of alternative factors on the clients' behaviour. The students also identified the issue of "the health visitor as a family visitor" as an area of confusion. The elderly and adolescents were client groups where inconsistency between theory and practice was specifically identified. However I would argue this finding demonstrates once more that the interpretation of professional practice is task orientated in both theory and practice and demonstrates the lack of a

conceptual framework for health visiting practice. I would also argue that it is significant that some students articulated their desire to practice differently from that of their FWT, which has particular implications for the student-FWT dialogue and establishing an effective practicum where conflicting demands are experienced by the student.

Role modelling: the influence on conflicting demands in the practicum

I would argue this finding has implications for the interpretation of professional practice, particularly in relation to the issue of role modelling. The significance of this phenomenon has been demonstrated in Chapter 6 and this issue therefore provided a further focus in the student data analysis. It is interesting that the response to this question during the interviews once more prompted an immediate spontaneous comment, whether positive or negative. Only 6 of the 12 interviewees perceived their FWT as a role model. This related explicitly to the standard of health visiting practice demonstrated by the FWT. This is illustrated by one student's comments "...yes I mean the thing is I think she is very good - it's difficult when you haven't had the experience but to me she just appears to be very good in a lot of ways and so I will probably always think of her as my little sort of role health visitor or whatever..." Although one student acknowledged that she would never achieve the standard of practice demonstrated by her FWT, this did not deter her from using the FWT as a role model. The influence of good health visiting practice was also illustrated in the comments completed by the students in the summative assessment procedure. Expressions such as "ideal example" and "observing the very high standards" were an indication of the role model provided by the FWT. The personality of

the FWT was also identified as an important issue. The FWT who was described as enthusiastic, knowledgeable and interested was unquestioningly a role model to the student. Dotan et al (1986:57) argue the importance of the personal attributes of role models. However it is significant that 2 students who stated that their FWT had not been a role model, also related this to the personality of the FWT. One student, although not criticising the FWT's standard of practice, said "...not particularly as we're such different personalities - she tends to be rather specific in her advice and I try to be a bit broader...". I would argue it is significant that the students identified domains of practice which explicitly influence the concept of professional artistry in practice when identifying the FWT as a role model. As previously described other students cited health visiting practice as the reason for not considering the FWT as a role model. This ranged from the student who did not respect the FWT's practice to those who described the FWT as too formal. Jarvis and Gibson (1985:15) describe the teacher practitioner as having no professional authority for the student who does not recognise the professionalism in the practice that she witnesses. This is substantiated by the student's comment "...it's respect for her practice that to me is all important...". Another student describes her FWT as a negative role model also related this to standards of practice. The conflicting demands of the practicum were further demonstrated in the students' interpretation of professional practice. The students expressed their feelings of confusion when experiencing conflicting paradigms of practice. One student described her feelings saying "...the GP attached (HV) - who has a totally different approach - it was quite a shock at first - I thought this is very strange...". Indeed another student felt she would have difficulty in identifying health visiting if she did not



agree with the FWT's practice. The conflict in practice was demonstrated by another student who commented "...I know what she perceived as needs are not what I see as needs and there is a bit of conflict there - I've given up trying to resolve that conflict - I just think when I'm out on my own I'll do things differently...". This issue was identified by other students who were concerned that their comments would be seen as criticism of the FWT's practice. However I would argue that this finding highlights once more the significance of the FWT-student dialogue.

The influence of the role model could also be identified when analysing the data relating to extra fieldwork practice. The data revealed the relationship between those students who considered extra fieldwork practice useful and those who considered their FWT a role model. Other students who stated they would like extra fieldwork in an alternative area all identified some criticism of their FWT's practice during the interview. This I would suggest demonstrates the conflicting demands created by the different interpretation of professional practice in the practicum. The above findings also demonstrate the significance attached by the student to the role model provided by the FWT. Rushton and Murray (1985:362) cite the study by Cohen (1981) which from written examination results indicated that highly rated teachers tend to encourage higher levels of student learning. It would be interesting to examine whether a similar pattern existed in fieldwork teaching where it is obvious that some FWTs are rated much more highly than their colleagues. But I would argue that a major finding relates to the inconsistency in the perception of role modelling on the part of the student and FWT. It is significant that only 4 of the 12 pairs of students and FWTs

agreed in their perception of whether the FWT was a role model to the student. Indeed some FWTs who stated that they considered this an inappropriate role to play, were identified by the student sample as a role model. This evidence suggests that the students base their professional practice on that of the FWT. This I would argue has implications for the assessment of competence in practice, particularly where the FWT does not recognise that she is a role model for the student.

#### The Student's Status: Implications in creating conflicting demands in the practicum

In addition to the conflicting demands created in the practicum by the process of socialisation into a new reference group, the students must also adapt to the added demands created by their student status. The age group of the student cohort ranged from 24 to 41, with some students having a long interval since their last experience of formal education.

Table 7.5

qualifications	n	%
No. of O-levels (or equivalent)		
1-3	3	12
4-6	13	50
7-9	10	38
No. of CSEs		
1-3	7	27
4-6	2	8
7-9	3	12
No. of A-levels		
1	5	19
2	4	15
3	1	4
degree	1	4
diploma in nursing	1	4

The academic qualifications of the students

Table 7.5 demonstrates the wide range of academic experience with 10 (38%) of the respondents having obtained one or more Advanced level passes in the General Certificate of Education and 3 (12%) three or less Ordinary passes. Hack (1983) argues that high achievers in the formal written examinations tended to be the younger students with 'A' Levels but found that age and conservatism were the most effective precourse predictors of post course achievement in the field (Hack 1986:245). Table 7.5 also demonstrates that only one respondent had a degree and therefore had any experience of higher education. As the majority of students had no experience of studying past the 'O' Level stage I would suggest this had implications for

their ability to cope with the written work and adjust to the student role. Although the written assignments have been identified as a major cause of stress in the course (Dingwall 1977, Hunkins 1985), other factors have been identified including aspects of fieldwork practice. Dean (1985:93) describes the uncertainty of role as a major stress factor, but also identifies fieldwork practice where she describes the student facing "the dual demands of academic and experiential content - a situation which appears to inhibit her full enjoyment of the fieldwork placement". (Dean 1985:95). The students' dilemma about their status during fieldwork (whether student or practitioner) emerged as a dominant theme in the data. Two specific areas of the questionnaire were used to generate data about their perception of their role as a student: whether the students were prepared to make written comments on their assessment and whether they consider it fairer if another FWT assessed their fieldwork practice. These were used particularly to identify whether the students felt confident in their student role.

25 (96%) of the student cohort stated they would be prepared to comment on their assessment. However it is interesting that only 4 of the 26 respondents had made relevant comments on either of the assessment forms. The term fair was used to describe their assessment by all 4 respondents and this was the dominant theme in the comments in the questionnaire. The effect of personality was identified as the major theme in influencing whether the students had made written comments on the FWTs' assessment of their competence in practice. This was presented in both a positive and negative form, some respondents stating they felt able to comment because they had a good relationship with the FWT, others because they had not experienced any clash of personality with their FWT. However several

students demonstrated their reluctance by stating that they would find this difficult to do particularly if disagreeing with the assessment. One student said she would "...shudder to criticise knowing there are still 2 more terms to go and I'm very much at the mercy of how hard and conscientious the FWT is prepared to be on my behalf...". The importance that the students placed on their relationship with the FWT was clearly demonstrated.

When asked if the assessment would be fairer if completed by another FWT only 4 (15%) of the respondents agreed. This was again related to the effect of personality, specifically to the issue of a personality clash and the degree of impartiality which would be obtained in an independent assessment. Amongst those students who did not agree that it would be fairer, the dominant theme identified the need for the FWT to get to know the student's practice before a fair assessment could be made. It is interesting that several students expressed concern about the suggestion and felt it would be impossible to organise. Concern was also expressed that it would not present a true reflection of the students' skills. It is significant that one student stated "...this would make it much more like an exam...". Indeed I would argue that this evidence substantiates the earlier findings which demonstrated that the majority of students did not perceive the assessment process as an examination. When the issue was explored further with the interviewees, some students had changed their opinion, indicating their uncertainty about the suggestion. The advantages were once more identified as resolving any issues in conflict in personality or lack of impartiality. However, the advantage of providing a different perspective the student's performance was identified and this concept had not arisen in the earlier questionnaire. This may suggest that some students

were becoming more confident in their student role.

However, I would argue that the analysis generally demonstrates the insecurity experienced within the student role. Although 18 (69%) of the student cohort agreed that the FWTs' personality influenced the assessment procedure, when asked if they considered it fairer for another FWT to make the assessment, only 4 (15%) agreed. Therefore 12 (46%) of the respondents acknowledged the influence of personality in the procedure but did not wish to have the impartiality of an unknown assessor. Comments made by this group included: feeling threatened, lack of confidence in the FWT's practice, conflicting ideas in practice and feeling of confusion. An observation made by one student demonstrated the conflicting demands of the practicum (and insecurity in her student status) by stating that "...you will have been taught your health visiting skills based on the method in which your FWT works - it may be completely different to that of another FWT which may cause her to be critical of your competence...". It is interesting that from my own personal observations these students had also demonstrated insecurity in their student status in college. This included being very defensive, failing to present seminar papers and overt anxiety about the marks awarded for written assignments.

I would suggest another factor influencing the perception of their student status relates to their feelings about the transition from practitioner to student. While (1981) observed that all the students in her study had been affected by the experience of undertaking the health visitor course. In the present study two students specifically identified the distress they had experienced in adjusting to the change in status. The transition from nurse to

health visitor student was described as painful and initially difficult. Indeed the data obtained from one student consistently demonstrated her difficulty in adapting to her new status. This issue was therefore explored during the semi-structured interviews by asking the interviewees if they considered they had changed while on the course. 4 of the 12 stated that they had definitely changed. This was related to personality traits they had identified within themselves which included being judgmental, dogmatic and self critical. It is interesting that these personality factors particularly influence the intuitive knowing in practice by which practitioners make sense of an individual practice setting to inform professional judgment to determine strategies in practice. However, further analysis demonstrated that all but one student actually described changes that had occurred during the year. The majority of the experiences related to the way they thought about issues and of being much more aware as an individual. One described it as "...knowing a bit more about who I am...". Indeed one student demonstrated clearly the problems of transition with the comment "...sometimes I catch myself saying things but make a joke of it - bits of psychology - but turn it into a joke." Another stated that she was "...beginning to feel less confident and competent now than I ever did". It is significant that both these students were in the group identified as being insecure in their student role.

#### Practitioner versus student: the conflicting demands of the practicum

However the demands of a practicum are such that the health visitor student is not only required to adapt to the student role but also rehearse her newly acquired practice in a supported setting. I would

argue this confusion in role expectations is a major cause of the conflicting demands of the practicum. One student described her feelings saying "...you really need to know what health visiting is all about - I can't see how you can do this by the end of the first term". Another student expressed concern that she was doing insufficient visits to clients and another felt overwhelmed by the amount of information she was expected to absorb both at college and in her fieldwork practice. The students not only identified the difficulty of being introduced once more as a student but also the feeling of offering a second class service to the client. The particular difficulty in managing a joint visit with the FWT was described. Some students found their role in this situation threatening and one described herself as always feeling a "...bit awkward with two of us trooping into a home".

It is significant that when the students were asked which areas of fieldwork practice they found particularly difficult, the conflicting demands of the practicum can be identified and are demonstrated in Table 76. Their perceived lack of skill in advising parents is an illustration of the conflicting demands experienced by the students. They considered that they should have a much greater knowledge base from the beginning of the course and wanted more information on specific topics such as nappy rash, weaning, crying babies and toilet training. I would argue this suggests that the students were attempting to fulfil a practitioner role rather than a student role. However it also identified a traditional interpretation of professional practice grounded in maternal and child health. Indeed I would argue that the data identifies once more the lack of a conceptual framework for health visiting. This is illustrated by a



Table 7.6

<u>Category</u>	<u>Practice issue</u>
client contact	lack of confidence forming relationships lack of elderly clients
home visiting	first client contact doing nothing practical visiting alone
role expectations	sufficient visits to clients overwhelmed with information changing role offering a second class service being introduced as a student joining in FWT and client discussion
HV practice	listening aims & objectives administration evaluation advising parents child health clinics planning priorities
FWT contact	physical space time for discussion
travelling	

Areas of difficulty identified in Fieldwork Practice

student's comment when asked what she hoped for in fieldwork practice: "...what to do...lots of little but important bits of information that can only be learnt from someone experienced in health visiting". Nevertheless, it is significant that students also identified those areas of practice which could be categorised within the more indeterminate zones of professional knowledge. Issues specifically identified were establishing relationships with new

clients and knocking on unknown doors not knowing what was on the other side. Indeed I would argue this clearly demonstrates an acknowledgment of the significance of the concept of professional artistry in the interpretation of professional practice.

The conflicting demands of the practicum could also be identified in the student's response to the suggestion that the course should contain more fieldwork. The dominant theme identified was the need to spend more time with the FWT as this would provide greater opportunities for learning. However the learning was related to experience and observation of the FWT managing different practice situations, rather than the student-FWT dialogue. Indeed one student stated that she was used to learning by observation and could gain significantly from this experience. Other students described feelings of concern about the lack of continuity offered to clients, the frustration of not being able to visit clients as often as they required and not being able to meet the needs of the clients. Nonetheless students also expressed their apprehension about the practitioner role and their lack of self-confidence during fieldwork was acknowledged. Significantly one student described herself as needing rather than wanting more fieldwork experience stating "...maybe because I can cope with theory better than practice - it's taken me an awful long time to get to grips with what I'm supposed to be doing". This I would argue highlights once more the gap experienced in professional education between theory and practice. However others related their feelings of uncertainty in the practicum not to a lack of self-confidence but of feeling awkward and being an encumbrance to the FWT. Indeed I would suggest that the conflicting demands experienced by many students is summarised by the comment "...it's very difficult to change from somebody in position of

responsibility and then converting that to being a student. You're a student and then you're in a position of responsibility as far as your clients are concerned - you don't know where you're at all the time...".

Although an implicit role of the practicum is to allow the student to rehearse her practice, I would argue these findings highlight the conflict this has for individuals within the student cohort, particularly in adjusting to different reference groups. Although a significant number of the student cohort had limited professional experience, I would argue they nevertheless demonstrated feelings of loss and vulnerability in the practicum which influenced their adaptation to the new reference group, particularly the student group. Indeed I would suggest the students perceived the two reference groups as conflicting rather than complementing one another, which also created conflicting demands in the practicum. Although I would argue that the majority of the students more readily adopted the culture and practice of the professional reference group, this in itself generated conflicting demands for the student as they felt limited in the extent to which they could fulfil this role. However, I would argue that where the student's interpretation of professional knowledge and practice differed significantly from that of the FWT additional conflict could be identified. Indeed I would argue that it is significant this finding particularly related to those practice issues which influenced the understanding and appreciation of the concept of professional artistry. The interpretation of practice and in particular the paradigm of practice presented to the student in the practicum therefore provided an additional focus in the analysis of the data.

iii) The conflicting paradigms of practice presented in the practicum

Although the data has clearly demonstrated the influence of the FWT in the students' interpretation of professional practice, I would argue that the students' interpretation of practice is also significant to their perception of the process of assessing competence in practice. However, since the students had not been asked in either the questionnaire or the semi-structured interview to discuss their interpretation of professional practice, it was necessary to sift the data to identify specific practice issues to demonstrate their individual interpretations. The survey question, relating to the criteria the students would use to assess competence in practice, identified practice issues which were considered significant by the students. The following criteria were identified by more than one respondent:

- client satisfaction,
- realistic priorities of clients' needs,
- communication,
- personal relationships.

I would argue it is significant that these practice issues not only specifically relate to an appreciation of the concept of professional artistry but also require a client centred approach to practice. Indeed it is significant that this approach to practice was not apparent in the criteria provided by the FWT cohort. The students' interpretation of a client centred approach to practice was explored further with the interviewees. The frustration experienced by the students when their perception of client need differed from that of the FWT could be identified. This was illustrated by a student describing her feelings when she considered that a particular client was exhibiting signs of depression which was disputed by her FWT. It

is significant that this not only supports the finding described by Hennessey (1985) of the lack of health visiting awareness in identifying and caring for women with postnatal depression, but I would argue also demonstrates that some students have a much wider interpretation of professional knowledge than their FWT which has implications when assessing competence in practice.

However, there was also consistency in the practice issues identified by the students and the FWTs. The importance of personal relationships was identified and this particularly related to getting to know the client/clients well. One student described health visiting as "...all to do with relationships and how you interact with people". I would suggest this once more highlights the significance associated with an appreciation of professional artistry in the interpretation of professional knowledge. The students' perception of the importance of the Child Health Clinic in professional practice was identified by their concern at their lack of experience in this field. This was particularly identified when discussing whether they needed extra fieldwork practice. Indeed one student described her feelings saying "...I think that clinic experience is vital because I used to hate clinics - I'm still not very keen but I feel less threatened than I did...". It is interesting that the students also considered the skills of health visiting more important than a theoretical approach to practice. The students linked their request for more theory in the course not to the need for a conceptual framework for practice but to specific skills such as advice giving. One student stated that "...there have been times when I wished that I had known a great deal more. I wonder whether the theory is given at the right time, and whether more of the basic problems such as feeding and sleeping problems

should be given earlier...". The issues on which they required more knowledge were those associated with a traditional interpretation of professional practice and included topics such as toilet training, crying babies, infant care and nappy rash. It is significant that only 4 (15%) of the students identified any relevance in any of the theoretical concepts included within the syllabus although interestingly some respondents considered that the relevance would become more apparent as they became more experienced in fieldwork practice. Indeed I would argue therefore that the findings demonstrate that the majority of the student cohort did not perceive the need for a conceptual framework for practice within the interpretation of professional knowledge. Although this finding correlates with that demonstrated by the FWT cohort, I would argue this has serious implications not only in facilitating the development of a reflective practitioner but also in assessing competence in practice.

The data demonstrate that the majority of the students' interpretation of professional practice reflects a traditional paradigm grounded in maternal and child health and therefore correlates with that presented by the FWT cohort. However, although the students' interpretation of professional knowledge encompasses the concept of professional artistry, I would suggest that they do not acknowledge its significance to competence in practice which once more correlates with the data obtained from the FWT. However I would argue that conflict occurs where the student has adopted the non-directive individual paradigm of practice described in Chapter 1. This implicitly acknowledges a client centred approach to practice which directly conflicts with the philosophy adopted in the directive-individual paradigm demonstrated by many of the FWT cohort.

This fundamental difference in practice suggests conflicting paradigms of practice, which not only has implications for the assessment of competence in practice but also for the effectiveness of the practicum.

iv) The students' perception of the effectiveness of the practicum

The effectiveness of the practicum is not only influenced by the student's ability and willingness to step into the learning situation but also by the learning experience which is provided for the student. Schon (1987) argues that the experience must reflect practice reality. However the FWT when providing the student's experience must not only acknowledge her own interpretation of professional practice but also the demands of the caseload. The student's placement in the practicum is currently decided on by the lecturers in health visiting and generally two criteria are employed: the travelling time from home to the practicum and the Health Authority (HA) seconding the student. Due to the location of the case-study college the student's placement may be either inner city or suburban. During the study year twelve HAs had seconded students to the course and of these five could be described as inner city authorities. Indeed Jarman (1983) demonstrated that four of these HAs were ranked within the top fifteen of the most underprivileged in a study of forty seven. 10 (37%) of the student sample were placed within these HAs for their fieldwork experience, which may have implications for the interpretation of professional practice. Only one HA at this time required the students they had seconded to be placed with FWTs working within the HA. Due to travelling difficulties three other students were also placed in the seconding HA for their fieldwork placement. This resulted in 6 (23%) of the students practising in the same HA for fieldwork and supervised

practice. Another 7 (27%) students did their fieldwork in a similar HA to that seconding them for the course. However this left 13 (50%) of the student respondents being placed in a learning environment where the interpretation of practice may not only be influenced by the FWT's understanding of professional knowledge but also by the demands of the caseload. This has implications particularly where a task-orientated approach to practice is implemented. This may result in students having to significantly adapt their interpretation of practice once qualified (McClymott 1980). I would suggest these factors must be considered when exploring the student's perception of the effectiveness of the practicum.

The number of clients allocated to the student by the FWT range from 9 to 15 with only 9 (35%) of the respondents receiving 13, the number recommended by the College.

Table 7.7 classifies the client groups provided within the student workload and demonstrates that all students were allocated clients in the under 5 age group. 24 (92%) had been allocated ante-natal clients although it is interesting that only 14 (56%) of this group recognised prospective fathers as a client group in their own right. The allocation clearly establishes the traditional paradigm of practice presented to the student. The table demonstrates that the majority of students considered they had experience with clients from an ethnic minority, but only 13 (50%) had experience of working with the elderly. It is significant that only 1 (4%) student considered that she had any contact with community groups which substantiates



Table 7.7

Group	no. of students
ante-natal women	24
ante-natal men	10
0-12 months	25
13 months - 5 years	25
6-16 years	10
child with disability	12
single parent family	19
adult with disability	5
ethnic minority	20
community groups	1
mentally ill	0
elderly	13

NOTE: One student failed to complete this question in the questionnaire

Client groups identified in the students' workload

the work by Drennan (1985) describing the lack of health visiting involvement in community initiatives. This highlights the lack of practitioners adopting a collective paradigm of practice described in Chapter 1.

The students were also asked whether they had any opportunity of working with other members of the Primary Health Care Team (PHCT). This was used both to establish their perception of the PHCT and as a method of comparing the learning opportunities created to develop skills in teamwork (which is considered fundamental to practice [Stat. Instrument 1983]). 11 (42%) of the respondents did not consider they had worked with any other health professional during

this first term of experience. One student, who was placed in a GP attachment, stated that she had had very little contact with the GP and the situation had not changed by the end of the course. Another student explained the lack of contact by describing her FWT as saying "...that College told her I was not to gad about too much".

Table 7.8

professional group	number
GP	7
CMO	7
HV	7
school nurse	5
district midwife	3
clinic nurse	3
FP nurse	2
speech therapist	2
specialist HV	2
community physio	1
CPN	1
community dietician	1
social worker	1
district nurse	1

Professionals identified by students as members of the PHCT  
ranked in frequency of citation

Table 7.8 demonstrates those professionals included within the students' perception of the PHCT and identified the number of times that the individual profession was cited by the student. It is interesting that Clinical Medical Officers (CMOs) and GPs are cited equally as members of the PHCT, although many GPs dispute the

contribution that the CMO has to offer primary health care (RCGP 1983). It is significant that only one student had the opportunity of working with a district nurse, thus supporting the findings of the Community Nursing Review (1986), which highlighted the lack of contact between health visitors and district nurses. When the issue of the PHCT was explored further by asking the students which other professionals they had come into contact with during fieldwork practice all but three of the respondents identified no other health or allied professional. This I would argue once more demonstrates the traditional paradigm of practice adopted by FWTs.

The practicum must also represent the reality of practice and the students' perception of this phenomenon was explored by asking how their workload compared to that allocated to their peer group. 18 (69%) of the respondents described similarities in practice. Significantly this was related to the practice setting in which they were placed not to the interpretation of professional practice. However, the students did identify the elderly as a client group omitted from their workload. Those students who did not consider their workloads similar identified factors such as: the lack of breadth of their fieldwork experience, the lack of contact with clients from an ethnic minority or disadvantaged groups and the routine inclusion of the elderly. When asked if they considered the selection of clients appropriate, their response was related once more to the practice setting of the FWT rather the interpretation of practice. This was illustrated by comments such as "...fair choice of types of client limited by fieldwork area..." and "...an appropriate selection from my area as they represent common needs and situations...". The client groups identified by students as being under-represented included the elderly, antenatal clients and ethnic

minority groups. Some students felt able to correct the omission of certain client groups from their workload by negotiating specific learning experiences with their FWT. I would argue that it is significant that the students interpreted their workload using a task-orientated client group approach to practice which has implications for their interpretation of the reality of the learning experience and thus the effectiveness of the practicum.

Their perception of the reality of the learning experience provided in the practicum was pursued by discussing with the interviewees whether they had any concerns about the appropriateness of fieldwork experience. Half of the group stated this was not a problem they had experienced. This was related both to the practice setting and to the quality of the learning experience, once more demonstrating the importance of the FWT-student dialogue. Those who were concerned identified the factors such as: the combination of social groups, the lack of any crisis work and the lack of elderly clients. The FWT's practice was also identified with one student saying "...areas like health education are taboo...some areas I feel a little bit lacking - but they're her priorities - it's not her it's the way the job goes". It is interesting that although this student had identified both the interpretation of professional practice and the practice setting as issues which had influenced the learning experience, she did not acknowledge the fundamental role played by the individual FWT in the effectiveness of the practicum. Another student identified the important role played by the FWT in the effectiveness of the practicum, by acknowledging that she could not identify the learning experience she had missed and therefore would be unable to rectify the situation. This I would suggest has implications for the student's interpretation of professional

practice.

It is significant that there was considerable difference in the students' and FWTs' perception of the reality of the practicum which I would argue demonstrates once more the different interpretations of professional practice. Some FWTs' opinions directly contradicted those of the student particularly in relation to the inclusion of elderly clients in the workload. Other FWTs disagreed with the students' perception of the lack of reality in the practice setting. In one situation the FWT's concern was the high concentration of social class 4 and 5 and the lack of non crisis work, whereas the student was concerned about the lack of elderly clients. Another FWT expressed her concern about the high level of social need and once more the student's concern related to the lack of elderly clients. I would argue that it is significant that the omissions were related specifically to client groups, once more illustrating the task orientated client group approach to the interpretation of professional knowledge. This has implications not only for the effectiveness of the practicum but also for the assessment of competence in practice. However, I would suggest that the other important issue to emerge from the data once more is the influence of the FWT in the interpretation of professional practice which in turn has implications for the assessment process. This issue therefore provided the final focus in the analysis of the data.

v) The influence of the FWT on the process of the assessment of competence in practice

The influence of the FWT on the effectiveness of the practicum has previously been described. This relates not only to the FWT's interpretation of professional practice but also to the quality of

the student-FWT dialogue which initially will be influenced not only by the FWT's ability to reflect-in-practice but also by the personality of the FWT. Schon (1987:168) argues that a student's failure to grasp a practice issue may say more about the failure of the FWT to "negotiate the ladder of reflection" than the student's inadequacy. Indeed I would suggest these issues will also influence the process of assessing competence in practice, particularly as the personal attributes of the FWT have been highlighted as influencing the student's perception of the FWT as a role model. When the possible influence of personality on the process of assessment was explored with the students in the questionnaire only 5 (19%) of the student cohort agreed with the suggestion. The predominant theme related to the inevitability of the situation. However some of the students identified specific personality traits in their FWT which they considered influenced the process and these included embarrassment, committing judgements to paper, an authoritarian approach and the "type of person who doesn't like to sit beside you." The student-FWT relationship was also identified, particularly in relation to a personality clash between the two individuals. One student described her feelings saying "...the relationship between the student and FWT would colour her views as to the competence of the student - also the FWT's personality, values and attitudes do influence her views of the student". However 8 (31%) of the sample did not consider the personality of their FWT affected the assessment of the student's performance, although they recognised the possibility of this situation arising amongst FWTs. The predominant factor amongst these students was the professionalism of their FWT in preventing this phenomenon occurring. One student was quite emphatic that although she and her FWT had different personalities and ethnic origins this had not affected the FWT's assessment of her skills in

health visiting. Indeed I would suggest this illustrates the high expectations some students have of their FWT. However I would argue that it is significant that although 13 (50%) of the cohort recognised the influence of personality on the assessment procedure, they were not happy with the proposal that another FWT should assess their competence in practice. This I would suggest highlights their acknowledgement of conflicting interpretations of professional practice and the perceived implications for the assessment process.

The influence of personality was explored further by asking the interviewees if they considered their FWT was objective about their performance. The majority of the students considered that their FWT was objective in her assessment of their performance. However the data demonstrate the personality of both the student and the FWT being significant in the objectivity of the process of assessment. This is illustrated by one student's observation saying "...but I don't think even if she had a bad relationship it would come into it - but that's personality on her part - really people do differ...". However two students were emphatic that their FWT experienced difficulty in being objective. In both instances this was related to the FWTs' interpretation of professional practice thus establishing set criteria for appropriate practice. Although one student acknowledged she was uncertain whether her FWT could be objective she considered that objectivity must be "...highly coloured..." because the FWT-student relationship was so good.

However when the issue was pursued further with this group of students by asking them to identify factors which they considered influence objectivity, the personality of the FWT was the dominant theme in the data. One student identified the trait of prejudice and

linked this specifically to racial issues; however the majority of the students did not consider the ethnic background of the FWT was significant to the assessment process. Difference of opinion on fundamental issues such as contraception, breast feeding and religion was also identified and highlights the influence of values in the process which is particularly relevant to the wider practice issues which influence the interpretation of professional knowledge. It is interesting that the gender of the FWT was not considered significant by the student group and there was no evidence of the prejudice towards male health visitors as demonstrated by the FWT cohort. The age of the FWT was also not considered a hindrance to objectivity, although the students identified a similar problem to one noted by the FWT sample: the difficulties which may arise when an older student with considerable life experience is placed with a young FWT.

Although the dominant factor identified in influencing the objectivity of the FWT in the process of assessment was the personality of the FWT, students identified other personal attributes which they considered affected the objectivity of the process. These were: feeling threatened, feeling inferior, lacking in confidence and an over zealous approach. Indeed I would suggest these traits play a significant role in the quality of the student-FWT dialogue, particularly in influencing whether the dialogue attains the ideal of reciprocal reflection-in-action. Indeed I would argue that in addition to the interpretation of professional practice the quality of the FWT-student dialogue influences the process of assessing competence in practice. This demonstrates once more the fundamental role played by the FWT in the effectiveness of the practicum.



## Conclusions

I would argue that the findings demonstrate the limited learning experiences provided in the practicum for many of the students. This has implications not only for the students' interpretation of professional practice but also the assessment of competence in practice. The data also illustrate that the majority of the student cohort interpreted professional practice in a traditional way demonstrating a paradigm of practice grounded in maternal and child health.

Although the concept of professional artistry could be identified by certain practice issues, such as the influence of role modelling, I would suggest this was not acknowledged as a fundamental component of competence in practice. I would argue that this evidence reflects the lack of a conceptual framework for practice, particularly in providing a foundation for the student-FWT dialogue. Indeed I would suggest that the majority of the dialogue arises from a task-orientated client group approach to practice which has implications for effectiveness of the practicum and in turn the process of assessment.

However, while exploring the students' perception of the role model not only was the significance of the FWT-student relationship highlighted but also the fact that some students recognised that their interpretation of professional practice differed significantly to that of their FWT. This not only generated conflict in the practice offered to the clients, but also questions the quality of the student-FWT dialogue and must question the validity of the assessment process. It also raises the issue of the status of the

student during her experience in the practicum. The data clearly demonstrate the conflict generated for students in adapting to their new reference groups. I would argue the students more readily adapt to the professional reference group and actively fulfil a practitioner role for the client throughout much of their time in the practicum. This must once again question the role of the FWT-student dialogue and certainly questions the ability of the FWT to facilitate the student's development as a reflective practitioner. In addition it must raise questions about the FWT's role in the assessment process. Indeed it is interesting that a significant proportion of the student cohort did not perceive their FWT as an assessor of their competence in professional practice. However, I would suggest that the ambivalence of the students in fulfilling this practitioner role is demonstrated in their attitude towards the suggestion that an independent FWT should have responsibility for assessing their competence in practice. Despite the students recognising that issues such as the personality of the FWT, the teacher-assessor relationship, the influence of the role model and the teaching ability of the FWT may influence the assessment process, half the cohort expressed their reluctance in having an independent FWT involved in the procedure. I would argue this demonstrates in addition to the students uncertainty in their interpretation of professional practice, their apprehension about receiving professional criticism of their practice. These issues have particular implications for the process of assessing their competence in practice.

However, despite the clearly acknowledged role of the FWT in the interpretation of professional practice and the effectiveness of the practicum, the students also acknowledged the role that clients play

in the provision of the experience of the practicum. It is interesting that although some of the students acknowledged they were threatened by the involvement of clients in the assessment process they also recognised client satisfaction as an important issue in the assessment of their competence in practice. This was particularly related to what they described as the reality of the practice presented by them to clients. It is also significant that the majority of the students were not concerned about the client's ability to interpret professional practice. Indeed I would suggest this reflects the students' acknowledgement of the importance of an understanding and appreciation of the concept of professional artistry in the competent practitioner, despite not specifically articulating it as a fundamental component of practice. The client's interpretation of professional practice and their perception of their role in the practicum therefore provided the focus for the next stage in the analysis of the data.

- (1) As part of the course the ENB require the students to complete a week of fieldwork practice in another placement which demonstrates an alternative interpretation of health visiting practice.

## CHAPTER 8

"There are things that happen in real families that wouldn't crop up in books": the clients' perception of their role in the practicum

The previous discussion has identified the practicum as a setting designed for the specific task of enabling the student to learn a professional practice. Within the practicum in health visiting the student takes on practice situations under the close supervision of the FWT. The direct participation of clients in student learning and indeed in the informal if not the formal process of assessing competence in practice (Dean 1981) is therefore implicit within the practicum. Although this experience provides the student with the opportunity of learning the reality of professional values, roles and boundaries within a protected environment, it introduces an additional dimension into the context of health visiting education: the clients' previous experiences and expectations of health visiting practice. This phenomenon I would suggest raises specific issues in relation to the effectiveness of the practicum; in particular the clients' interpretation of professional practice and their perception of their participation in the students' learning environment.

The data used to explore these issues were obtained from semi-structured interviews with clients, about their perception of the competence in practice of student health visitors. The clients lived in four Health Authorities representing both inner city and suburban environments. 33 clients were approached by 11 FWTs and all agreed to be interviewed. However it is interesting that of this original cohort 9 did not respond to my follow up letter arranging a

time for the interview to take place (Appendix N). I did not pursue the non-respondents as I interpreted this response as an indication that they had changed their minds about participating in the study. However, as with the non-respondents in the FWT, lecturer and student cohorts I acknowledge that these respondents may have provided a valuable source of data for the study. All the clients were women, although during two interviews their partners were present and participated in part with the interview. 2 (8%) of the respondents were black and interestingly were the only single parents in the cohort. Although I had not commented to the FWTs on the type of client group for selection, I would suggest it is significant that all the clients had young children. This I would argue once more reflects a traditional paradigm of practice grounded in maternal and child health. Table 8.1 demonstrates the spread of social class within the cohort using an occupational classification (OPCS 1980). Although an opportunistic method of sampling was used it is interesting that this spread generally reflects the national trend of the social class of families with young children (OPCS 1985).

TABLE 8.1

I	II	III N	III M	IV	V	unemployed N
1	3	6	6	4	1	3
4	13	25	25	17	4	13
						24
						101

Note: percentages have been rounded up to whole figures therefore do not equal 100%

The Classification of social class of the client cohort by occupation of the main income earner.

Although 12 (50%) of the cohort were classified within social class 3 this had not influenced the use of the preventive health services. This study reflects that of Mayall and Grossmith (1985) and is in contrast to other surveys demonstrating a higher up-take of services

for individuals classified as social class 1 and 2. Although a choice of venue was offered for the semi-structured interviews all the women chose to be interviewed at home. When exploring the reason for this choice the predominant theme to emerge was one of feeling more relaxed and at ease in their own home surroundings. One mother commented that it was harder for the interviewer to walk into her home, thus giving the advantage to the client. All the participants were willing to have the interview taped although one woman during the discussion acknowledged that "the tape-recorder puts you off slightly". However, nobody appeared overtly anxious about the use of the tape-recorder.

The women were also asked if they felt they would have answered any questions differently if they had been interviewed with a group of parents. I considered it important to include this question to establish whether they considered their responses had been inhibited by the one to one relationship with the interviewer (Polit & Hungler 1987). Only 2 (8%) participants stated that they would have answered some questions differently. One said that she would find the negative things much harder to say and the other stated that she would think more about the answers before she spoke as "...you don't want to say something that somebody is going to think a stupid comment...". I would suggest, however, that it is significant these were the only women who had made any negative comments about the student's performance. It was perhaps more significant that it was the same student in both instances. Another woman commented that she may have felt more relaxed with other women present, although this observation was related specifically to the use of the tape-recorder. However she went on to state that "...you can talk at more length when it's one to one...". Another 2 (8%) women were

undecided and related this to the fact that although they would not have answered the questions differently, friends would have offered totally different answers to some of the questions. However 19 (79%) of the sample stated that a group interview would not have made any difference to their answers. The predominant theme to emerge was one of feeling free to say what they wanted to. Although some related this to their personality, giving examples such as out-spokenness and the ability to speak their minds, others simply did not feel inhibited by the interview situation. However 4 (17%) women specifically related their answers to their experience of good health visiting practice with one client saying "No because I think she's good". Another was less emphatic but commented "Perhaps it's because I've had a good health visitor". I would argue that these findings demonstrate that clients' not only construct their own interpretation of professional practice but are also willing to comment on their perception of standards of practice. This I would suggest has implications for the process of assessing competence in practice.

However, a significant finding to emerge in the initial analysis of the data was the spontaneous recognition amongst the cohort, that other clients had very different opinions of the effectiveness of health visiting practice. Several respondents commented that although they would not have answered differently, a group interview would provide evidence of the differing opinions on many of the issues raised. One client identified the advantages of this phenomenon commenting "...I would have perhaps have thought of more to say because when there are more people there - they give other ideas and perhaps thoughts that you might miss...they seem to spur you on more...". Although the clients were specifically commenting

on their perception of the effectiveness of health visiting practice, (which in part I would argue is influenced by the individual practitioner) I would suggest that their perception is also influenced by their expectations of health visiting practice. The clients' interpretation of professional practice therefore provided a fundamental focus for the data analysis.

#### The clients' interpretation of professional practice

Within the current framework of health visiting, a client's interpretation of professional practice will be mainly the consequence of direct contact with an individual practitioner. However recent studies (Mayall & Grossmith 1985, Moss et al 1986, Field et al 1982, Draper et al 1983) have demonstrated the diverse patterns of practice amongst health visitors and indeed Watson (1986) has highlighted the mismatch between clients and practitioners in their perception of effective practice. One particular issue which illustrates this phenomenon is the client-practitioner relationship. Although some studies (Orr 1980, Robinson 1982, Lowe 1985, Hennessey 1985) have clearly identified the importance of the client-practitioner relationship in influencing the client's perception of health visiting practice, other research demonstrates that individual practitioners seem unaware of the importance of this relationship, in determining the effectiveness of practice. Indeed Field et al (1982:301) described the stereotyped views of health visitors held by clients as "young, childless and ignorant, or old, childless and out of date". Although perhaps an extreme example other studies have highlighted similar findings (Lowe 1985). However I would suggest that this evidence also highlights the significance of the concept of professional artistry in determining the effectiveness of practice.



Indeed I would argue that it is not merely the personal attributes of the practitioner which dictate the clients' perception of the effectiveness of the intervention, but the intuitive knowing in practice by which practitioners make sense of the practice setting to inform professional judgement and determine strategies in practice. However an essential process in exploring this hypothesis is to analyse the clients' interpretation of professional practice and therefore this issue provided the initial focus in the data analysis.

As research (Clark 1984a) has demonstrated the difficulty experienced by clients in identifying the role of the health visitor, the participants in this present study were asked to describe any aspects of health visiting practice which they had experienced as either particularly helpful or unhelpful. It was interesting that when the participants were asked specifically to identify any health visiting intervention which they considered particularly helpful, only one client was unable to offer an example. She commented "...not really, because they don't have to tell me a lot because usually I know it you know...". However later in the interview she described quite explicitly the help provided in acquiring and completing an application form for day care provision. I would argue this statement supports the evidence demonstrating that some clients perceive health visiting as being child-focused, which highlights the traditional paradigm of practice described in Chapter 1. However those aspects of practice identified as being particularly helpful could be classified within four practice issues: advising, providing information, client advocacy and offering support. Client advocacy has been defined in this context as a practitioner representing (as if they were her own) the

interests of a person who has major needs which are unmet and likely to remain unmet without special intervention (Hannan 1988). It is significant to note that giving advice was cited by a greater number of clients as a negative experience. I would suggest this relates directly to the understanding and appreciation of the concept of professional artistry displayed by the practitioner.

However those parents who found advice giving useful related it to specific problems such as sleep difficulties. The clients could be categorised into two groups: those who wanted to be told what to do and those who wanted to know the advice but then would make their own decision about managing the situation. The importance of the advice being down to earth and practical was clearly identified. Another important role was that of providing information which related both to specific topics and general child care. One woman commented "...with your first baby you're so worried you don't know anything". The role of client advocate was clearly demonstrated and linked to housing and financial needs, as well as to the hospitalisation of children. One mother described her experience at a hospital appointment in "a room full of top nobs" and said she felt "...comfortable that she (the health visitor) was there by my side if I should fumble along". However, the main role was described as giving support. This could be categorised as listening, acting as a "sound board" and responding to the expressed needs of the client. Indeed I would argue it is significant, that research has demonstrated the art of listening as a competence which many practitioners find particularly difficult in practice situations; not only by initiating topics but also by controlling the conversation (Seffi 1985). Acting as a sounding board was related to enabling decisions about issues such as immunisation and

solving personal problems. Others described the importance of the practitioner responding to expressed needs. One client commented "She came when I screamed for her...or I don't think Lisa would have lived for six months ...". Another described it as "...asking someone to come and visit - no matter how trivial she's not going to think you're making a fuss about nothing...". Giving support was considered particularly important by the clients and this was described in terms of "just knowing there was somebody at the end of the phone; nice to know someone's taking an interest and always being there...without pushing herself on us". Indeed the importance and value attached to the role of listener is demonstrated throughout the data, therefore playing an significant role in the clients' interpretation of practice.

The negative experiences identified by the respondents also demonstrated the clients' perception of health visiting practice. The role of advising was once again cited, but in this instance specifically to the issue of conflicting and inappropriate advice. Conflicting advice was particularly related to infant feeding and inappropriate advice was highlighted as a source of distress and anger by several mothers. One described her feelings as "...having my own ideas and sometimes I sit in here and think 'yes but I'm not going to do that'". It is significant that two clients made similar observations about the performance of one particular student in relation to the giving of inappropriate advice, an observation which I would argue directly relates to the concept of professional artistry. Another said "...if their advice had been contrary to what I believed I wouldn't take it...you have to draw the line with the health visitor". This argument is supported by De'Ath (1984) who argues the importance of health professionals making joint

decisions with parents if health care is to be truly effective. However, it is interesting they also described their reluctance in sharing their disagreement about the advice with the practitioner and this I would argue relates particularly to the attitudes and personal attributes of the practitioner. I would suggest it is significant that clients were able to recognise incompetence in professional practice in the advice they were offered. One woman described her friend's experience with "...a very young one (health visitor) that didn't know one end of the baby from the other". Another expressed anger at the health visitor giving advice based on personal experience with her own children.

Other negative examples of practice particularly illustrated the central role played by the Child Health clinic. The predominant theme related to the time the clients waited to see health professionals. Nicoll (1983) argues that many clinic attendances are unnecessary which creates the excessive waiting time for clients. The premises were also identified as being unsuitable: either too cold or too small. One mother particularly described the lack of privacy saying "...I only go to get him weighed - I don't really use it for anything else because there's always people listening". Concern was also expressed about the competence of the individuals working in the clinics, with the example being given of "...two very elderly ladies who weigh the babies and you have to check it because they usually write it down wrong". I would argue that this evidence substantiates the earlier finding of an interpretation of practice grounded in maternal and child health.

Child protection, particularly in relation to identifying and monitoring children at risk of child abuse, provided a further focus

to the data analysis. Dingwall (1982:340) argues that one of the strengths of health visiting practice is the "non-authoritarian style of dealing with clients". Despite current concern that students receive inadequate training in working with families at risk of abusing their children (Sharman 1985, Brent:L.B. 1986, Greenwich:L.B. 1987), my original schedule for the semi-structured interviews did not address this issue (Appendix L). I was concerned that clients would find this topic too intrusive. However I would suggest it is significant that during one of the early interviews the topic emerged spontaneously during the discussion, with the client commenting "I think health visitors are the first ones who would know - with my husband being a policeman I do know about it and there is far more than people realise". She went on to describe very candidly her experiences and feelings having attended the local casualty department with her son who had delayed concussion following a fall. Following this interview I acknowledged that not only were clients prepared to discuss this issue, but it may also influence their perception of health visiting practice. I therefore included the topic in the later interviews although unfortunately it was not discussed during the first three interviews.

It is interesting that individually the clients did not perceive the practitioner in a child protection role. However this observation was qualified by many of the clients demonstrating that they considered it part of health visiting practice. This is illustrated by comments such as "No I've never felt that but I'm sure they do - I think it's a credit to them that I don't feel as if they are doing it". Others felt it was appropriate that the standard of child care was monitored by the practitioner and one client commented "No,

sometimes I think they should come round more often - they don't know what I'm doing to my kids". Others stated that they might feel differently if they had something to hide. Another client actually stated that her relatives said the reason for her frequent contact with the health visitor was related to the practitioner's concern about the standard of child care. However she went on to say "that's not the way I look at it...I really do think she's more concerned about me than the baby...". However 3 (14%) of the 21 respondents described feelings of being monitored. An example is given by one saying "Yes, sometimes - it's probably just the questions they ask. You might think they're a bit personal but you answer them anyway". Another commented that the feeling disappeared when she "knew what health visitors were". Interestingly, one client said "Well I can't really say a lot - I've always seen my health visitor when I have needed to...so I'll abstain from answering that". Unfortunately I did not feel it was appropriate to pursue this comment. Despite this comment I would argue that the evidence demonstrates an interpretation of practice which specifically identifies child protection as a practice issue. It additionally highlights the clients' perception of the practitioner as an individual in authority, which supports the argument suggested by Dingwall (1982) that health visiting is a method of case finding for the State.

Indeed a particularly significant phenomenon to emerge from the data was that although the majority of the cohort had not personally experienced feelings of 'social policing' (Dingwall 1982) they spontaneously described individuals (both friends and relatives) who did. One client described her sister's feelings saying "but then I think the health visitors are checking up on her". This evidence

must also raise the question of whether the phenomenon actually reflects the true feelings of the clients on this issue by projecting their feelings onto a third person. However I would argue that the appreciation of the concept of professional artistry demonstrated by the practitioner directly influences the clients' perception of this practice issue.

The clients' perception of their partner's role in the interaction with the practitioner also demonstrated their interpretation of professional practice. When clients were asked if they had discussed the suggestion of having a student working with the family with their partner, before agreeing to be involved in student training, the predominant theme was one of irrelevance. Their responses included: not being interested, not having anything to do with them, always being at work and not considered part of his role. This is illustrated with the comment "You tell them in the evening but they're not involved...I don't think mine worries one little bit". Another stated "Really it's nothing to do with him because it's me that's seeing her". I would suggest that the two fathers who were present during the interviews were there because of their pattern of employment rather than specifically wanting to participate in the study. Although they both made some contribution, with one becoming increasingly involved towards the end of the interview, their main interest remained with the television programme. The client's perception of the status of the health visitor in relation to the medical profession also demonstrated a traditional paradigm of practice. The health visitor was described as being consulted when issues about the child's health were considered too trivial to consult the General Practitioner (G.P.). This finding is illustrated by the comment "It

was nice to phone her - whereas I would have dashed up to the surgery which would have been a total waste of their time and mine". Another client commented "You can't call the doctor for every least little thing". Interestingly, one woman actually expressed her anger that doctors and health visitors did not work closer together and went on to describe the dismissive attitude of her G.P. towards the health visitor stating "the health visitor should be treated better and not like they're some silly woman who tells mothers to take their babies to the doctor just for some little thing...probably if they all worked better together there would not be so many hassles over child abuse and that sort of thing". However it was not possible to identify practice issues which clients considered the specific responsibility of the health visitor rather than the doctor.

Therefore although the selection of the client cohort biased the interpretation of practice to that of a traditional paradigm grounded in maternal and child health, with a particular focus on child health, I would argue that the data also reveal a task orientated interpretation of practice. Indeed clients particularly identified practice issues such as sleep and feeding problems. It is interesting that child protection was clearly identified within their interpretation of practice and considered a legitimate role for the practitioner. However, I would argue that it is significant that even within this traditional individual directive paradigm of practice, the data reveal the implications of not only the intuitive knowing in practice but also the personal attributes and attitudes of the practitioner on the outcome of practice strategies. Indeed I would argue that these two issues: the intuitive knowing in practice which informs and determines professional judgement and the personal



attributes and attitudes of the practitioner must be considered when exploring the clients' perception of competence in practice. The clients' interpretation of the significance of the personal attributes and attitudes of the student therefore provides another framework for the data analysis.

The significance of personal attributes and attitudes to competence in practice: the clients' perspective

The argument presented by Schon (1987) suggests that it is the processes employed by practitioners in their understanding of knowing-in-action, tacit knowing and intuition when making professional judgments which in part determines competent from incompetent practice. However I would argue that within the context of health visiting, this process is also influenced by the attitudes and personal attributes of the practitioner. Although the interview schedule did not include a specific question relating to the personal attributes and attitudes of the practitioner, the initial analysis of the data highlighted the significance of these issues in the clients' perception of professional practice.

Indeed I would suggest it is significant that several different topic areas generated comments which related specifically to the attitudes of the practitioner and the implications for effective practice. The clients' negative experiences in health visiting practice particularly identified attitudes which were considered inappropriate. These were specifically related to experiences in the Child Health Clinics, and identified as: interfering, nosey, uncaring, knowing it all and patronising. Interestingly, however, once more they were not directed towards the health visitor

currently working with the client. One woman described a previous health visitor as "a bit of a tyrant, a big woman and just to see her thumping up the path used to petrify me, I was frightened to say anything...it seemed everything I was doing she used to pick holes in". It is interesting that appropriate attitudes could also be identified in two other main topic areas: discussing the difference in practice between the FWT and the student, and discussing factors which influenced whether they liked the health visitor. This issue was identified when clients spontaneously described feelings of liking or warmth towards their health visitor. Table 8.2 demonstrates those personal attributes described as important by more than one client and ranks them in order of the frequency that each was cited by the clients.

TABLE 8.2

<u>Personal attribute</u>	<u>frequency</u>
Easy to talk to	12
friendly manner	7
good listener	7
cares about children	5
caring attitude	4
approachability	3
down to earth	3
easy to get on with	3
makes people feel comfortable	2
cheerful	2
kind	2

N = 24

the clients' perception of those personal attributes appropriate for an effective practitioner ranked in order of frequency.

I would suggest it is significant that 12 (50%) of the cohort identified personal attributes which directly influence the client-practitioner relationship, thereby highlighting the significance of this issue in their interpretation of professional practice. Although a total of 27 different personal attributes were identified within the data, 15 of these were only mentioned by one participant. Although this demonstrates the range of attributes which may influence the processes employed in competent practice, one client clearly described her perception of appropriate professional attributes as: "likes children, likes people, quite patient because all mums ask silly questions and don't need to be snapped at in reply, likes babies - generally friendly - quite outgoing and extrovert without being nosey - they've got to have their heads screwed on...know what they're doing and know what they're watching out for". It is interesting that although adaptability was not identified specifically as a personal attribute, the data clearly demonstrate the clients' recognition and demand for advice and practice to be appropriate to the individual setting. This finding once more highlights the importance of the intuitive knowing in practice by which practitioners make sense of the individual practice setting to determine professional judgements, in the clients' interpretation of professional practice.

I would suggest it is significant that the data analysis demonstrated the correlation between the clients' perception of the quality of the health visiting intervention and their feelings for the practitioner. 10 (42%) of the cohort described explicitly their feelings of liking the practitioner. Indeed it is interesting that one student was described as being "too nice at the moment" since

she appeared to care too much about her clients. Both the women interviewed who knew the student made similar comments. It is also pertinent to note that they hoped she would not change when she was qualified, with the demands of a full caseload. Therefore the importance of liking the practitioner for their work to be effective was identified. This specifically related to "not bothering" if a client did not relate to the practitioner as a person. This finding was supported with comments such as "Yes, I wouldn't bother going to see them or listen to them or anything if I didn't like them as a person" and "...if you think they're an old dragon you don't bother do you?" Interestingly another woman commented "...if they don't like the health visitor they tend to think she's no good at her job". However other clients expressed their concern that a client could like the practitioner "although she had nothing to offer as a health visitor". Indeed I would argue that this evidence, despite demonstrating the correlation between the perception of practice and the feelings for the practitioner, identifies not only the complex issue of the client-practitioner relationship, but also that clients recognise the importance of identifying competence in practice.

Within the context of the personal attributes of the practitioner another important theme to emerge was the issue of the practitioner being a parent herself. Although once again not asked directly the issue arose in several topic areas. This particularly related to: negative experiences of practice, giving advice and the difference in practice between the FWT and the student. 12 (50%) of the women initiated the topic and of these only 2 did not consider parenthood an advantage. Although one actually stated it a disadvantage saying "...she has had too many children as far as I'm concerned", the

other said it did not matter "as they (the health visitors) had done their training". Those women describing it as an important issue particularly related it to the empathy demonstrated by the practitioner. This is illustrated by the comment "...if you've been up all night with him...they don't really know what you're talking about because they've never done it". In addition they wanted the health visitors to use their own experience in child rearing to resolve particular problems they were experiencing with their children. This evidence presents a similar pattern to that identified by Field et al (1982) who demonstrated that many women in their study believed health visitors should be parents themselves. Although this evidence once more reflects the importance of the personal attributes of the individual practitioner, I would suggest it also demonstrates the gap between theory and the reality of practice as practitioners are drawing on their own experience to supplement professional knowledge. However I would argue that the clients' perception of the use made by the practitioner of her personal experiences may also reflect the practitioner's ability to demonstrate an appreciation of the concept of professional artistry.

The age and ethnic background of the practitioner were the final issues to emerge from the data, highlighting the influence of attitudes and personal attributes to practice. Since none of the women had had any contact with a male practitioner, the influence of gender was not addressed within the data. It is interesting that some clients perceived the age of the practitioner influencing the quality of practice; in particular the older practitioner was identified as not keeping up to date with current ideas in practice. The younger practitioner was perceived as being easier to relate to and easier to talk to, which in part was ascribed to a modern

approach to life generally. However some clients presented an opposing view and this is illustrated by the comment "...well I know one that didn't like them because she had a very young one that didn't know one end of a baby from the other...it's very hard being young". Although the data demonstrate the clients' perception of the effect of the practitioner's age on the quality of practice, the interview schedule did not include a specific question relating to this issue. Therefore the data was obtained from several topics, in particular exploring the differences in practice between the student and FWT.

Once more the clients were not asked specifically whether they considered the ethnic background of the practitioner influenced their perception of professional practice. Despite all of the clients included in the study being visited by white health visitors, two of the 11 students involved were black. Although I could not identify any theme within the data which related specifically to the ethnic background of either the student or the practitioner, it is significant that 2 (8%) of the clients identified difficulties in communicating with the professionals. One commented "...the only thing I don't like about it down there (the child health clinic) is the doctor - being not of our race I don't understand what she is saying". The other, when describing the relationship with a student said"...I couldn't understand her accent - but she was ever so nice". This student, although white, had a strong regional accent. Indeed I would suggest that both these examples support the findings of previous studies recognising the importance attached by clients to the communication skills of the professionals. However, it was not possible to make any further observations from the available data.

Therefore I would argue the data demonstrate that although the majority of the client cohort exhibited an interpretation of professional practice grounded in a traditional paradigm, focussed on child health, the significance of not only the attitudes and personal attributes of the practitioner but also the concept of professional artistry is demonstrated within the context of that paradigm. The client, an essential component of the practicum, plays a fundamental role in the learning experience provided for the student. Therefore I would suggest that the effectiveness of the practicum will not only be influenced by the client's interpretation of professional practice but also by their perception of their role in the learning environment. This issue provided a further focus to the data analysis.

#### The Clients' perception of their role in the practicum

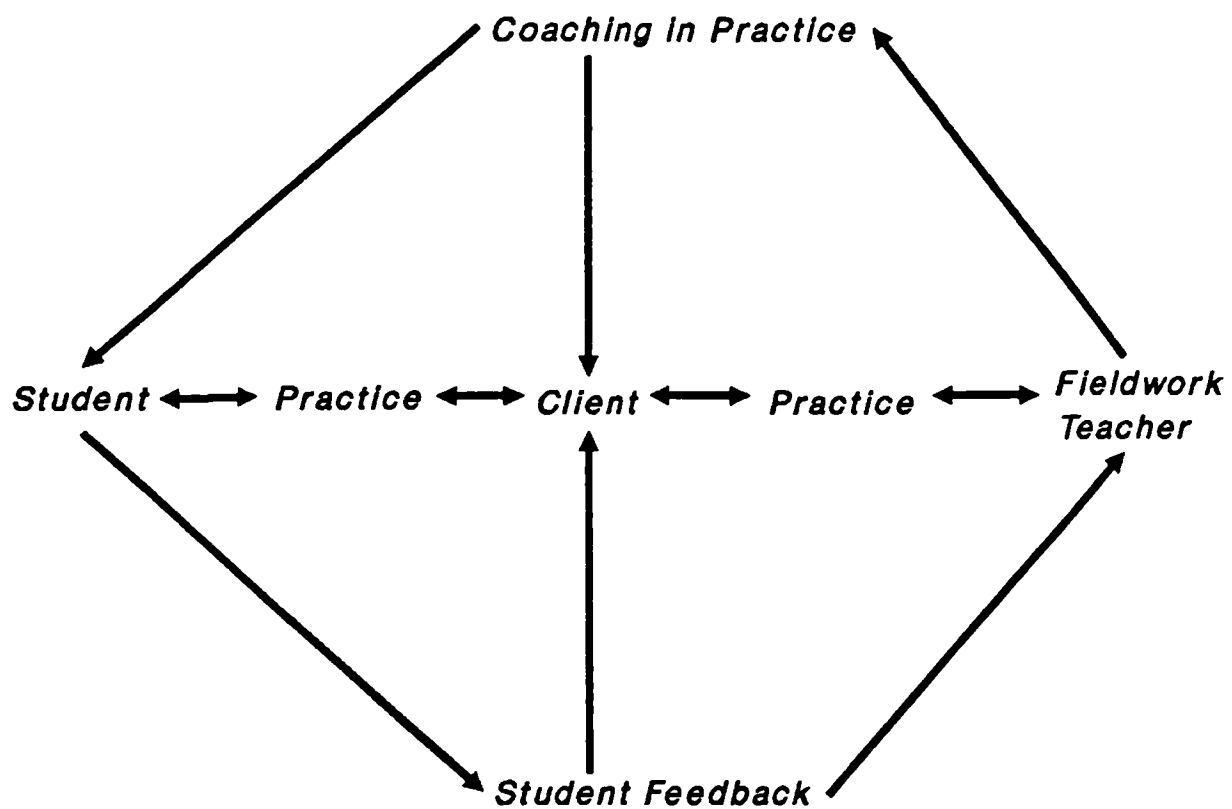
The practicum provides the student with the opportunity of rehearsing her practice under the close supervision of the FWT, who has the responsibility for guiding, criticising, analysing, reviewing and consequently coaching the student's practice. However, within this context the client is receiving care from both the FWT and the student. Indeed Smith (1977) describes the dual responsibility of the teacher and student in providing care for clients in the community; an issue which is particularly pertinent in health visiting where the majority of current practice occurs in a one to one situation in the client's home. This phenomenon results in the client receiving direct health visiting intervention from two practitioners simultaneously and research has clearly demonstrated the stress generated in clients when conflicting advice and care is offered (Downey 1987 & Bedford 1988). This situation

raises two specific issues when exploring the clients' perception of their role in the practicum: the relationship between the student, FWT and the client and their perception of the students' status during the learning experience.

The discussion in Chapter 6 has demonstrated the significance of the relationship between the FWT and the student in the effectiveness of the practicum. Indeed I would argue that the significance of the quality of this relationship extends to the client as she is not only directly influenced by the practice of both the student and the FWT but also has an individual relationship with both individuals. The processes involved in this interaction are illustrated in Figure 8.1.

Therefore the client's perception of the relationship between the student and the FWT provided an important focus for the analysis. The issue of the FWT and the student visiting the client together generated the majority of the data. The predominant theme to emerge was that the FWT and the student worked together as a team. This is illustrated by one client's actual comment "...they seem to work quite well together - they're like a team". Another described how a student told her that she would tell the FWT all that had gone on during the visit on her return to the office, particularly if she had offered any advice so that the FWT could contact the client if necessary. Others described their enjoyment of their experience of the joint visiting from the student and the FWT. The clients' perception of the strength of the relationship between the FWT and student was illustrated by two women who articulated their concern about assessing a student if their opinion was different from that of the FWT. One commented "...as she gets to like somebody then





Processes involved in the interaction between the client, fieldwork teacher and student

Figure 8.1.

she's not going to take kindly if you take a different opinion". This issue is discussed in greater depth later in the chapter. The quality of the relationship was also identified by the client's perception of the level of support given by the FWT to the student during the visit. One client observed that "...it seems as if Gemma said her piece and then she was waiting for Mrs White to say that she was right or wrong". Indeed another described the student as finding her FWT "a great help". I would argue it is significant that two clients identified the influence of role modelling in the relationship and one described her feelings saying "...a bit embarrassing if the fieldwork teacher asks you how you felt seeing as they worked so closely together - it would be harder to give my honest opinion". However the data also demonstrated that some clients identified the difficulties in the student-FWT relationship. The apparent lack of co-operation was illustrated by one client who commented "...I felt a bit sorry for Jenny sometimes...I felt that perhaps Mrs Lawrence wasn't as helpful as she might have been". I would argue that it is significant that the clients were able to identify the quality of the student-FWT relationship, particularly as in some cases this was described in terms of the personal attributes and attitudes of the student and practitioner. However, I would suggest the quality of the student-FWT relationship also requires addressing in relation to its effect on the individual client, particularly as this may have implications for the client's perception of her role in the practicum.

The data used to explore this issue was generated by asking clients to identify the similarities and differences in the methods of practice used by the student and the FWT. 14 (58%) of the cohort

stated that they both worked in a very similar way. The expressions used to describe the similarities included: down to earth, very easy going, cared about what we thought, same ideas and friendly feel. I would argue it is significant that all the factors related to the personal attributes and attitudes of the practitioner, once again highlighting the importance the clients attach to these practice issues. Although 7 (29%) identified differences in practice, in two instances this was related to the age of the student who was much younger than her FWT. However in both cases they qualified their comments with examples: one stated the student was a better listener, the other that the student was easier to talk to. However once again the other factors related to personal attributes and attitudes of the practitioner. These included: showing a greater interest in the family, being very authoritarian in giving advice, lacking in confidence and never having enough time for the client. It is significant that the clients again identified the concept of role modelling with the comment "...very similar - June's way has rubbed off on Jean (the student) probably - very similar people or seem to be". Interestingly another commented "...if they train them to be like themselves people like us aren't going to like them". Two other women felt unable to make a comparison because their contact with either the student or the FWT had been too limited. It is interesting that the practice issues identified in the similarities and differences in the practice of the FWT and the student, all related to the personal attributes and attitudes of the practitioner.

Indeed I would argue this finding demonstrates the significance of these factors in the client's interpretation of practice. In addition I would suggest that these practice issues also play a

significant role in influencing the practitioner's understanding and appreciation of the concept of professional artistry. It is also significant that of the four couples of FWTs and students, identified by clients as demonstrating conflicting approaches to practice, the individual student in each case had expressed concern about the quality of her relationship with the FWT. This I would suggest demonstrates that the quality of the student-practitioner relationship has implications for the role of the client in the practicum. It must also raise questions about the standard of care offered to the client, particularly in terms of conflicting practice.

A particular issue for those clients receiving conflicting approaches in practice must relate to whom the client perceives as the principal care giver. This is particularly pertinent to the clients' perception of their role in the practicum, since a fundamental aim of the practicum is to enable the student to rehearse her practice under the supervision of a skilled practitioner. The clients' perception of the students' status during their time in the practicum was therefore used to explore this issue. Although all the clients in the study sample had been informed of the student status of the individual, only 3 (13%) of the participants expressed any concern about a student working with the family. In two instances this related specifically to the level of knowledge of the student, and was illustrated by the comment "It crossed my mind but then Mary reassured me and said that if there was anything she didn't know she would always check". In the third case the client directly related her concern to her relationship with the FWT saying "...I was a bit worried at first because I did like Linda...I thought she was going to be mine all the time and I

didn't want to lose contact with Linda". However the predominant theme to emerge was their willingness to be involved with the student, particularly as they recognised that the FWT would maintain contact with the family. This is illustrated by one client saying "No, because Janice made it clear that if there was anything still worrying me that nobody would be offended if I decided to ring Janice and check with her". 4 (17%) of the clients specifically stated that they considered it an advantage and this was related particularly to the frequency of their contact with the practitioners. An example is given by a client who said "No, I probably thought I was gaining...She was round much more often and had more time". Others acknowledged that their acceptance of the situation related to the students' previous experience, particularly as they knew they were registered nurses with midwifery experience. However others simply felt that the students must get their experience somewhere. Indeed one client commented "No, it didn't worry me because I feel sorry for them...Whatever type of job - you've got to learn and you feel a bit nervous".

It is pertinent to note that although all the clients had been asked if they agreed to the student visiting, in some instances the request was made with the student present. One client described her experience saying "They came round when I was pregnant and she asked if I minded if a student health visitor visited me and I said no". However, I would suggest, that it is very difficult for the client to refuse to participate when the student is present, particularly when the health visitor is seen in a position of authority. This concept therefore provided another important focus for the analysis of the clients' perception of their role in the practicum. Only one client expressed any hesitation about families being used in student

training. She related this specifically to the age of her child commenting "No, but if she had been quite tiny then obviously I would have preferred to have had Mrs Brown - I was quite happy - I mean they've got to learn somehow". This feeling was expressed by the majority of women. Several commented it was the only way the student could possibly learn and practical experience was considered particularly important in jobs such as health visiting. One woman said "Like any trade, they've got to get experience or they don't get good at the job...there are things that happen in real families that wouldn't crop up in books". Another described her feelings saying "How are they going to get their experience if they don't - how is anyone going to learn anything if they haven't got something practical to work on - no as long as there's back-up and the actual health visitor". The importance of the support of the FWT was cited by several participants and I would argue demonstrates once more the significance of the student-FWT relationship. One client specifically expressed her pleasure at having been selected by the FWT saying "I feel pretty good Janice had chosen to put Sarah with us out of all the families that she has - I'm sure she wouldn't have put her here if she didn't think we would be interested". It is significant that these data demonstrate the clients' recognition of the gap between theory and practice which exists in professional education. I would argue also that the data demonstrate the clients' recognition that students need to relate theory and practice continuously if they are to develop the ability to reflect-in-action which is essential for the competent practitioner. In addition, the data demonstrated that the participants considered involving clients in student learning an advantage to the client. This was particularly related to the need for the students to have experience working with families prior to qualification, to offer an

alternative perspective of the students' performance and to provide an insight into the lives of different families. Indeed I could not identify any negative findings in the data, which I would argue demonstrates that the clients perceive themselves fulfilling a significant role in practicum in providing the reality of the practice setting.

Student or Practitioner: the clients' perception of the students' role in the practicum

However I would suggest it is equally significant to explore the clients' perception of the students' role in the practicum. The way the clients referred to the students and the FWTs, provided a focus for analysing the client's perception of the student's status during the practicum. It is interesting that although all the clients referred to the students by their first name, the majority of FWTs were referred to by their surnames. The predominant theme related to the status of the practitioner in particular that of authority. One client described her feelings saying "I don't feel I should call her Doreen. I don't know, I suppose that, that is - I'm a bit funny about authority". Another explained "I was brought up that people at hospitals, school teachers, were Mr and Mrs". Indeed, another client felt it kept the relationship on "a professional level". It is perhaps significant that both these FWTs were amongst the group who had been identified as practising differently from their students. Another FWT within this group referred to her clients by their surname although they referred to her by her first name. This I would suggest is another method of the professional controlling the client-health visitor relationship. Those clients who used the practitioner's first names attributed it to their relationship with the individual and this is demonstrated by such comments as "Janice

is as much a personal friend as a health visitor which is nice if you have problems which need confiding". Interestingly only one client considered it irrelevant what she actually called the health visitor. Although these data relate specifically to the clients' perception of their relationship with the student, I would argue they also highlight once again the importance ascribed to the personal attributes and attitudes of the practitioner.

The data generated from the issue of whether the clients had experienced any difficulties during the student's contact with the family, was also used to explore the client's perception of the student's status during the practicum. Indeed none of the clients had experienced any difficulties related directly to the student visiting the family and several were very positive about the experience. However three main issues were identified: one client commented on the age of the student saying "I was just surprised that she was older - when you think of a student you think of someone young", another stated "No, the only thing I found awkward was when Janice came with Sarah...I felt 'who should I be talking to?' I wasn't clear who was watching who". The final issue was identified by a client saying "No, sometimes I thought perhaps I was asking her too many questions - putting too much strain on her". Other clients clearly demonstrated their perception of the practitioner role fulfilled by the student. 3 (13%) clients identified the similarity in the role of the FWT and the student. One commented "I saw her as a health visitor...I never thought of her as not trained- she seemed so experienced that I sort of thought she was able to help me really". The predominant theme was that the students were helpful and able to offer advice. This is illustrated by one client's comment "I don't feel that she couldn't answer



anything I asked her - she's doing her job - I don't feel 'you're no good Pat' I would ask Anne (the FWT) the same questions". Another actually preferred the student stating that "She's a lot easier to talk to - she puts you first, you know what I mean". Other clients identified factors which demonstrated the student status: lack of confidence, just watching a child's progress and creating anxiety in the student by asking too many questions. However, it is significant that others specifically saw the student in a learning situation. This was illustrated with the comment "...with a second child it was a waste of time from my point of view - I wouldn't say she wasn't learning anything but I didn't find it helpful". Another example was provided by the comment "I think a lot of people who Brenda goes to and visits are fairly lonely and bored and enjoy it". Indeed several women described their interest in the student's course and what they were doing.

The clients' perception of the students' status during the practicum was explored further, using data from the discussion on the clients' expectation of the students' level of knowledge. It is interesting to note that there was a correlation between those women who placed the student in the practitioner role and satisfaction with the advice they were offered. One woman said "She gave me all the things about the injections telling me what might happen and what to look for - she gave me all the stuff". Whereas a client's comments about a student who was merely perceived in a learning situation was "She's a little bit 'you must do this, you must do that' which I found - the issues I remember were vitamin drops and safety at home - how I was going to move everything and I wasn't going to do it". However, I would suggest that several clients recognised the student's role in the practicum by acknowledging their admiration

and trust in those students who were prepared to admit the gaps in their level of knowledge. One client commented "She said that if there was anything she didn't know she would always check - so she never pretended she knew something she didn't - she always said 'I'm sorry I don't know that but I'll look into it' - she was very good like that". Another actually described it as "...like driving a car, you don't really start until you've passed your test - it's a matter of experience", clearly demonstrating her understanding of the aim of the practicum.

However the students' status in the practicum was less obvious when the clients were asked how they would have managed the hypothetical situation of being unhappy about their participation in the practicum. Indeed it is significant that the predominant theme was one of uncertainty. This was described by words such as 'probably, suppose, awkward' and 'think'. However the difficulty that many women would have experienced in sharing their feelings with the FWT was striking. One woman said "I think I would have got in touch with Janice - I wouldn't have been able to say to the student - I did think at the beginning 'what would I do if we didn't get on', may be it's a good thing to let people know if they don't get on with the student, they can let their health visitor know". Another said "It probably would have taken a week or two to think about it because I'm one of these people who would think 'perhaps you're being silly - perhaps you got off on the wrong foot'". I would argue it is significant that 5 (21%) of the clients felt they would allow the situation to continue. One demonstrated confusion by saying "I think I would have gone and said - I probably would have waited until the thing had finished - I don't know - I might have gone to Mrs Lawrence and said 'well I don't really like her' ".

However, several women said they would have contacted the FWT, clearly demonstrating they would not have found it difficult to complain about the student. One woman described her feelings saying "I would have rung Deborah (the FWT) - difficult but she would have had to have been quite horrible - quite bad - as I thought I was helping Deborah out I would have rung her up and asked for some else". Some of the women commented that although they felt able to inform the FWT, other women might not and this was a cause of concern.

The discussion about the client's contact with the FWT and any change they had perceived in this during their participation in the practicum, provided the final issue to explore the client's perception of the student's status in the practicum. Although the predominant theme was that they had not experienced any change in their contact, several women related this to their perception of the service. One commented "No, because once you've had a baby and she knows everything is basically alright it's left to you to go down to the clinic". Others stated that they felt they still had access to the FWT and continued to phone her and go to the Child Health Clinic specifically for advice. However, it was not possible to determine from the data whether this was due to lack of confidence in the student or because the student was unavailable. Those who had perceived a change described it only in terms of less contact; not as changing their relationship. One woman said "Jenny seems to have taken over a bit of the load from Mrs Lawrence - she's there if I really need her...oh yes, I've phoned on a couple of occasions". Although they acknowledged they had less contact, this had not created any anxiety as the FWT was available if required. It is interesting that 3 (13%) described themselves as "gaining" from the

students' involvement. One described her feelings saying "Yes I have seen her (the FWT) less - it hasn't worried me, I've still been able to get the help I've wanted - in fact I saw her (the student) a lot more often than I did Leslie - so I didn't miss out, I got extra".

Therefore although the data demonstrate a consensus amongst the client cohort about their role in the practicum, I would argue it is significant that their perception of the students' role differed substantially. Some quite clearly perceived the students' role as that intended in the concept of the practicum: the students rehearsing their practice in a protected environment under the close supervision of an experienced practitioner. Although others perceived the student as a practitioner with similar skills to that of a FWT ( and therefore made complex demands of the students' practice), others identified the student purely in a learning situation. Indeed they did not perceive the student offering effective health visiting intervention. This evidence highlights the range of the clients' perception of the students' status in the practicum, which I would suggest not only has implications for their participation in the learning processes in the practicum, but more significantly in the process of assessing competence in practice.

#### Assessing competence in practice: the client's perspective

Clients have been involved in the training of student health visitors since the introduction of the revised syllabus in 1966. However their involvement in the process of assessing competence in practice has been limited to an informal level. Indeed the earlier discussion in Chapter 6 has highlighted the dilemma experienced by FWTs in acknowledging the client's assessment of the student's

performance. Pollock (1983) demonstrated that patients' views of the nursing care of students in general nurse education were of considerable value, particularly when assessing the affective domain of their nursing skills. She also demonstrated that the patients in the study were very willing to participate in the assessment procedure. However I would argue it is significant that both learners and the teachers expressed some doubts about the patients involvement in the process because of their patient status. Although the clients participating in the practicum in health visiting are not sick, they have a variety of health needs which may influence their ability and willingness to participate in the assessment process. It is also significant to note the perceptions of some students of the different client groups involved in the practicum. This is illustrated by one student who commented "There are quite a lot of difficult families out there in the community. Not just the odd one...there are some people who will never listen or just don't want to". Indeed I would suggest this type of comment not only reflects the student's interpretation of practice but also highlights the significance of the intuitive knowing in practice demonstrated by practitioners in making professional judgements to competence in practice.

However I would also argue that the initial findings in the data analysis not only demonstrate the significant role that clients play in providing the reality of the practice setting but also in identifying the personal attributes and attitudes of the practitioner. Therefore I would suggest that the clients have a significant role to play in the process of assessing the student's competence in practice. This issue therefore provided the final focus for the data analysis.

I would argue it is significant that the majority of women felt able to give an opinion about their perception of the students' competence in practice. As identified above this particularly related to the reality of the practice setting and the personal attributes and attitudes of the individual student. An example is given by one client saying "I'd say yes - I would have liked to have been involved because June's (the FWT) opinion might have been different to mine...the family might have had a different experience with the student". As previously identified Watson (1986) demonstrated that clients' perceptions of effective health visiting intervention do not always reflect the views of the practitioner. The importance of the personal attributes and attitudes of the practitioner in health visiting was once more identified. Several women identified the personal attributes of the students when stating their willingness to be involved in the process. This is illustrated by the comment "They've got to be a certain type of person to do these jobs - it's one of those jobs you have got to have a feeling for - I didn't have that problem at all because she was so good - she was a natural". However other women expressed some reluctance in their ability to make that judgement. It is interesting that some women felt that this was because they were not qualified to offer an opinion. Indeed one commented "Well I'm not qualified really to make that - but I would think she'd make an excellent health visitor". Another related it to the amount of experience the parent had had of the health visiting service saying, "It's an easy question for me - we've had 3 children and 5 different health visitors. But perhaps someone that hasn't had as many babies might not be able to answer it - after all what is a good health visitor?". Indeed 3 (13%) of the client cohort actually stated that

they would find it difficult to give an opinion on the student's competence in practice. Although one related this specifically to the responsibility of making that sort of decision, another related it directly to her opinion of the student's practice saying "I think we probably could contribute - it would be more difficult if we felt the student wasn't very good - you don't like to put someone down when they're training". Therefore I would argue that the findings demonstrate that the client's willingness to participate in the process is not only influenced by the client-student relationship but also by the client's perception of the student's personal attributes and attitudes. I would suggest this particularly relates to the sensitivity and adaptability demonstrated by the student. Indeed it is significant that when clients were asked to identify the reasons for describing the student as an effective practitioner, the majority of factors related to the personal attributes and attitudes of the student rather than their skills and practice. These are identified in Table 8.3.

This demonstrates the importance clients attach to the personal attributes and attitudes when deciding their opinion of the student's competence in practice. It is interesting that although negative factors were actually expressed by one client, she acknowledged the positive attributes of the student. The negative

TABLE 8.3.

Personality Factors

friendly manner  
interested in the family  
get on easily  
listens  
'a natural health visitor'  
understanding  
easy to talk to  
time for parents  
sympathetic  
caring  
acknowledges thoughts of parents  
kind  
nice  
persuasive  
sense of humour

Practice Factors

asking appropriate questions  
answering questions  
giving the right information  
giving suggestions  
'knows what she's doing'  
tries to do things for you

The factors identified by client cohort in describing whether the student is perceived as an effective practitioner.

factors specifically related to the skills of the student in the affective domain, demonstrating a similar pattern to the findings in the study undertaken by Pollock (1983). Indeed some clients actually identified aspects of the student's practice which required improving or modifying. These were: communication, caring too much, inexperience and using their own experiences of motherhood. It is interesting that in some instances inexperience was related to the lack of having children rather than the students' level of knowledge. However this directly contradicts the feelings of



another client which I would suggest highlights once more the significance of the intuitive knowing in practice of the practitioner in determining strategies in practice.

Clients were also asked directly if they considered it too difficult to be involved in the assessment process. Although the majority did not consider it too difficult for them to give an opinion, it was possible to identify specific themes revealed by the data: the problem of subjectivity, the importance of the clients' opinion and the importance of their opinion only being part of the assessment procedure. It is interesting that the issue of subjectivity in assessing the student was recognised. This was illustrated by one client commenting "I think she'd have to ask questions around it rather than say - because that's - simply yes or no and it may depend on what mood you're in". However several women were emphatic that professionals did not attach enough importance to the opinions of consumers. Nonetheless the predominant theme amongst those clients who considered the process too difficult related to their perceived lack of knowledge of the criteria which required assessing. One woman said "...because I don't know what qualities the authorities are looking for - you can ask how we see Jenny on our side of things - how we find her as a person - but job-wise I wouldn't really know". The difficulty of participating in the process when they did not like the student was also identified. Indeed another client expressed her concern about how she would feel having to say the student was no good when she thought "...their job is hanging on it". This once more highlights the significance of the student-client relationship. I would suggest that it is significant that on further analysis there was a correlation between those women who were anxious about participating in the process and their

perception of the students' role in the practicum. Indeed it is significant that only one of these clients had identified the student fulfilling an appropriate role in the practicum. The others had described the student as merely fulfilling a learning role. I would suggest this once more highlights the importance of the role of the FWT in coaching the student in the practicum.

Having identified that the majority of the clients were willing to participate in the assessment process the next stage in the analysis was to establish the clients' perception of the most appropriate method to carry out the process. The clients were asked directly how they would like to be involved in the procedure, with two alternatives being suggested in the interview schedule: an interview with the FWT or completing a questionnaire which would be returned to the college. It is interesting that the clients were very divided in their opinions about the most appropriate method. 8 (33%) stated that they considered an interview or talking to the FWT would be the most appropriate. The reasons given were: a dislike of completing forms, concern that general impressions could not be expressed on paper, the ability to express themselves more effectively verbally and to enable more information to be obtained about the students' performance. Indeed one client said "I'd prefer to be asked questions - things that you wouldn't think to put down on the questionnaire, one thing could lead to another". I would suggest it is significant that these clients also raised the issue of the information being confidential. However 9 (38%) stated that they would rather complete a questionnaire. The predominant theme to emerge was that they felt it would be easier. This related specifically to the issue of their relationship with both the student and the FWT. The clients were particularly concerned that

they would find it difficult to share their feelings about the student with the FWT. This is illustrated by the comment "...the questionnaire would be better - if you're face to face then you're not going to say what you really feel - Deborah had them working with her. You're not going to say 'I don't think much of her'". However one client commented "It's only if you really like your health visitor you're going to tell her the truth - perhaps both ways should be offered and choose which would be best for you". Indeed, 5 (21%) actually stated that they did not mind or did not know and these feelings are illustrated by one comment "I don't know really - see, what to me is right isn't necessarily right for someone else - so long as it's clear it's just how I feel, it wouldn't worry me either way". It is interesting that 3 (13%) actually offered the alternative of an independent person undertaking the task of interviewing the clients and saw the researcher as being the ideal person to fulfil this role. This role was illustrated with a comment such as "I think a meeting like this would be a good idea - with you - whereas with Janice I might be just giving her an opinion because I talk to her as a friend". The difficulty was particularly related once more to giving an honest opinion of a student's performance and it was considered much easier with someone unknown to the client. Therefore although the clients expressed their willingness and interest in participating in the assessment process their hesitation in selecting the appropriate method was clearly identified.

Indeed I would argue that the data demonstrate that although the clients are willing and able to participate in the process of assessing the students' competence in practice, the appropriate method to use in undertaking this task is difficult to establish. I

would suggest this relates not only to the student-client-FWT relationship but also to the clients' perception of the role the student has performed in the practicum which indeed is in part dependent on the coaching of the FWT.

### Conclusions

I would argue that the data demonstrate the significant role played by the client in the student's learning experience in the practicum. However, the effectiveness of that role is influenced not only by the clients' interpretation of professional practice but also by those issues inherent to the practicum: the student-client relationship, the FWT-client relationship, the student-FWT relationship and the quality of the coaching provided by the FWT. It is significant that the clients specifically identified an important aspect of their role in providing the reality of the practice setting. A recurrent theme throughout the data identifies the significance of the personal attributes and attitudes considered appropriate to the competent practitioner and highlights the influence of these issues in the outcome of health visiting intervention. The clients clearly articulated how these practice issues influenced not only the processes involved in the students' practice but also their interpretation of professional practice, the students' role in the practicum and their assessment of the students' practice. Indeed I would argue that it is significant that the clients also demonstrated their ability to differentiate between the student who was merely liked and the student who was perceived as competent in practice. In addition I would argue that the data demonstrate the significance in the clients' interpretation of professional practice of the intuitive knowing in practice by which practitioners make sense of the individual practice setting to

inform professional judgements. However I would suggest that personal attributes and attitudes play a fundamental role in influencing the practitioner's understanding and appreciation of the concept of professional atistry.

Although the data demonstrate the willingness and ability of clients to participate in the practicum, the factors impeding their participation are also highlighted. I would argue that the relationship between the individuals participating in the practicum is central to this issue. The relationship between the student and FWT will influence the quality of coaching that is provided. This in turn will influence the students' ability to undertake a practitioner role, which may influence the student's relationship with the client. The client-FWT relationship provides a further dimension in influencing the effectiveness of the practicum and I would suggest highlights the significance of role modelling in the practicum. However, once more I would argue that central to these issues are the personal attributes and attitudes of the student and practitioner. Indeed I would argue that these are significant in influencing whether the client is willing to participate in the process of assessing the students' competence in practice. Although there are difficulties in clients participating in this process, I would argue that the data demonstrate that clients have a clear understanding of the personal attributes, attitudes and interpersonal skills necessary in the competent practitioner. Their perception of effective health visiting includes practice issues, which are particularly difficult for the FWT to assess and relate specifically to the affective domain of the students' performance. Therefore I would argue that the clients' ability to articulate the factors which they consider important indicators of competence in

professional practice fulfil an important component in the assessment process. This I would suggest reflects the fundamental role that clients play in the practicum, both in student learning and assessment. In addition I would suggest that their role contributes to the students' perception of their transition from the practicum to practice during the period of supervised practice.

## CHAPTER 9

### The transition from practicum to practice: the implications for the interpretation of professional practice and the assessment of competence in practice

The transition from practicum to practice requires the student to adjust to the reality of her practice world, including the pressures, risks and distractions found in the individual practice settings (Schon 1987). Supervised practice was introduced during the revision of the health visitor course in 1965 to allow the student to make a gradual transition from the practicum to practice. Indeed this period is described as enabling the student "to consolidate knowledge and practical skills learned during the academic year in a working situation" (CETHV 1982). However, I would suggest it is significant that this description does not address either implicitly or explicitly the intuitive knowing in practice by which practitioners make sense of the practice setting to inform and determine professional judgements. This is in contrast to the findings cited earlier, demonstrating the concern experienced by individuals within the client cohort that the student's practice would change once qualified. The emphasis on an epistemology of practice grounded in a model of technical rationality, rather than that of reflection-in-action, raises the issue once more of not only the interpretation of professional practice demonstrated by the student during this period, but also that of the practitioner responsible for her supervision. This in turn has implications not only for the methods used during this period to assess the student's competence, in practice but also the validity of those procedures as perceived by those individuals involved in the process.

The procedures used to assess this final stage in the student's education and training include both a theoretical and practical component. The theoretical component has been included in this present study as it is based on the student's perception of the health visiting intervention offered to client groups during the practicum. The practical component involves an assessment of the student's competence in practice during supervised practice and an oral examination at the end of this period of practice. These procedures, which have been previously described in detail in Chapter 2, have implications for the students' interpretation of professional practice during this transitional stage of the student's course. Although an essential component of the process used to assess competence in practice, I would suggest it is significant that I omitted these procedures from my original study protocol. I would argue that this highlights a phenomenon experienced by many practitioners: the perception of the course as two distinct phases rather than a continuum of professional development. Indeed I would suggest this has implications for the student's interpretation of professional practice in the period of supervised practice. This issue therefore provided an important focus in the confidential questionnaire circulated to the student cohort on completion of the course (Appendix P). At the time of the empirical work (in 1984), evidence suggested that the three procedures, namely, the period of supervised practice, the health visiting studies and the oral examination, were assessed independently; a situation which I would argue has implications for the extent to which practitioners perceive the procedures as a valid method of assessing competence in practice. This is particularly pertinent when students have passed the health visiting studies but failed the oral examination. These issues



therefore also provided a framework for the analysis of the data obtained from the confidential questionnaire, the postal survey and the semi-structured interviews with students, FWTs and lecturers in the case study college. However as there are three specific procedures involved in this stage of assessing competence in practice each will be considered in turn in relation to these issues. Supervised practice provides the initial focus as this is a fundamental component of this stage of the students' training.

#### The period of supervised practice

This period of training was introduced in 1966 and extended the course from nine to twelve months. During this period of practice, which must be a minimum of nine weeks, it is recommended that students are given the opportunity to extend and practice their skills in a working situation "allowing sufficient independence yet offering support and advice" (CETHV 1982:33). However I would argue that the guidelines provided for the size of workload and the type of health visiting experience available to the student during this time, once more highlight the emphasis on a model of technical rationality. Although the students' placement for supervised practice is arranged by the seconding or sponsoring Health Authority, the educational institution retains the responsibility for ensuring that the placement is appropriate. However if this placement offers the student a significantly different practice environment to that experienced in the practicum, I would argue this raises the question as to the extent to which this period may be considered one of transition. This raises three specific issues which were addressed within the confidential questionnaire circulated to the students:

- to what extent was the student provided with the opportunity of extending the practice issues developed in the practicum?

- to what extent was the student given professional independence during this period of transition?
- what was the student's perception of the validity of the procedures used to assess competence in practice during this stage of training?

21 out of 27 students returned the completed questionnaire giving a response rate of 78%. This compared with a response rate of 96% for the initial questionnaire completed during the course. However it is interesting that one student completed the final questionnaire who had not responded to the initial request. One respondent was not currently practising in health visiting as she had married and moved to a new area where there were no vacant health visiting posts. 14 (67%) of the respondents, once qualified, remained in the placements allocated to them during supervised practice: the traditional practice in health visiting education. However, of those students who had changed posts on qualification, the following reasons were cited: "difficult journey, lack of vacant posts, maternity leave and bureaucratic incompetence". Indeed I would suggest it is significant that only one of these students had actually requested a change in position. Although an equal number of students were practising in either a G.P. attachment or a geographical placement, a significant proportion of these students had changed their practice setting from that experienced in the practicum. Indeed I would suggest that this situation influences the extent to which the student is able to consolidate and develop the interpretation of practice experienced during the practicum. This issue therefore provided the initial focus for the data analysis.

The period of transition: the students' perception of their opportunity to extend the interpretation of practice developed in the practicum

The difference in the interpretation of professional practice amongst individual practitioners and indeed amongst practitioners and clients has been highlighted throughout the data. The influence of the FWT on the students' interpretation of professional practice has also been demonstrated in Chapter 7. I would suggest both these factors are significant when exploring the students' perception of the opportunity to extend the interpretation of professional practice developed in the practicum. When the students were asked to identify similarities and differences in the practice setting between the practicum and the period of supervised practice, the majority of students identified differences in practice. One student described the two experiences as "totally different" and cited the social class of the clients, unemployment rates, the ratio of clients from an ethnic minority group and housing conditions as the reason for this observation. Table 9.1 demonstrates the frequency by which differences in health visiting practice were cited by the student cohort.

TABLE 9.1

Practice Differences

The Socio-economic group of clients	10
Work with the elderly	6
Clients from an ethnic minority group	5
Crisis work	4
Unemployment rates in client groups	4
Housing of client groups	3
Travelling Families	2

N = 21

The Students' perception of the differences in health visiting practice between the practicum and Supervised Practice

Although the students' perception of the influence of the socio-economic status of the clients is clearly demonstrated, particularly by the student who commented "at first I felt how can I speak about health if housing and finance are their main worries", I would argue it is significant that the practice differences are once more grounded in tasks and client groups. This I would argue demonstrates the lack of emphasis on the significance of an appreciation of professional artistry in competence in practice. Indeed I would also argue that the data reveal the emphasis on an epistemology of practice grounded in a model of technical rationality. This finding is illustrated by the comment "I felt I had had no grounding in approaching and dealing with people who perhaps didn't want to see a health visitor". Therefore although the data demonstrate the students' perceptions of differences rather than similarities in the two practice settings, I would argue that the interpretation of practice remains grounded in a traditional paradigm of maternal and child health. However, it is significant that in

neither practice setting is the student provided with the opportunity or experience of developing the ability to reflect-in-action.

When the issue of the students' perception of the practicum as a means of preparing them for practice was explored in more depth, 12 (57%) of the students expressed negative feelings. The predominant theme related to specific practice issues, in particular giving advice to clients. One student described the practicum as "being insufficient for me to come across and know the answers and advice that mothers needed to questions on bringing up children which I became inundated with once I was out full-time - my colleagues gave me tips on advice to give out". Another described herself feeling "stunned" by the amount of detailed information clients requested. The Child Health Clinic was also identified as an area of insufficient experience and this issue occurs as a recurring theme throughout the data. I would argue it is significant, that both the giving of advice and the experience of Child Health clinics, were identified by clients as practice issues, which were particularly dependent on the practitioner's ability to use her intuitive knowing-in-practice to inform and determine professional judgements. It is significant that other practice issues which involve the use of intuitive knowing-in-practice such as assessing priorities in the workload, and home visiting were identified as being particularly stressful for the students during this time. Although much of the stress of newly qualified practitioners is related to child abuse (Dauncey 1986, Appleby 1987), only 2 (10%) of the student cohort cited this issue. I would suggest that this phenomenon is explained by the fact that the majority of the students were not actually working with families where the children were known to be at risk. This once more raises the question of the extent to which supervised

practice can be described as a period of transition, particularly as 3 (14%) of the students stated that families or clients who had been identified as having either an overt social or medical problem had been removed from their workload.

It is also pertinent to note that the students actually articulated their concern about the adequacy of their experience in the practicum in preparing them for supervised practice. One student commented "Fieldwork practice gave me only a flavour of health visiting - this is not a criticism of fieldwork practice - it was all that was possible in the time available". This feeling of inadequacy in preparation was also demonstrated by the students' dependence on health visiting colleagues. 17 (81%) described their colleagues as an extremely useful source of knowledge and practice advice. One student expressed her feelings stating that colleagues were "extremely useful in not only supervised practice but also the first 6 months afterwards - mainly in getting their advice as to how to deal with the practical problems that mothers were asking me for help with - if I couldn't answer problems I met during the day my colleagues gave me tips so I could return to the client with constructive help". These findings demonstrate the students' perception of an epistemology of practice grounded in a model of technical rationality which has serious implications for not only the interpretation of professional practice but also assessing competence in practice.

It is significant that in the student group expressing positive feelings about their experience in the practicum, the influence of the individual FWT was once more highlighted. One student described her feelings saying she was "well prepared during fieldwork practice

due to an excellent FWT". Another went on to identify the areas where the preparation by the FWT had been particularly helpful: undertaking a Child Health Clinic on her own, contacts she should make with other services, keeping up to date in changes in practice and policies in the area and discussing families in depth. However, it is interesting that another student, despite a positive experience in the practicum stated that it was not until the "student health visitor is undergoing supervised practice that she is exposed to the full responsibility of the role of the health visitor". This finding raises questions once more about the effectiveness of the practicum, particularly in relation to the FWT's ability to not only reflect in practice but also to reflect-in-action. Other comments demonstrated the ambivalence of the students' feelings. Although they acknowledged that the practicum had provided a good foundation for practice, students expressed reservations about the value of the experience in an environment which differed considerably to that of supervised practice. A student commented "I'm not sure of the value of experience given in an inner city area when one ends up in suburbia and vice versa". It is significant that this theme was also demonstrated by those students who considered their experience in the practicum negative. I would argue that these data highlight the significance of using a conceptual framework for practice, in addition to basing the curriculum on an epistemology of practice grounded in reflection-in-action in order to prepare the student to meet the demands of the individual practice setting. Implicit within this framework is the need for the student to develop an understanding and appreciation of the concept of professional artistry.

Indeed, I would also argue the data raise questions as to the extent

to which supervised practice acts as a period of transition for the student. This relates not only to the interpretation of professional practice but also the use made of supervised practice by the student and undoubtedly some supervisors; with some individuals clearly favouring the model of the practicum rather than a period of transition from student to practitioner. Indeed I would question whether it is possible to achieve this transition within this time span and there is little evidence to justify the selection of the current period of nine weeks. Wilkie (1979:25) argues that the difficulties in designing the revised syllabus, related directly to the concern that the course would be "unattractive to candidates who had already spent not less than four years in professional training". Indeed financial constraints governed the decision to implement the current period of supervised practice, rather than the learning needs of the student. It is significant that my concern about the length of supervised practice, and the need to introduce a probationary year of practice, is shared by other members of the profession (NSC 1980; DHSS 1986).

The Extent to which students were given professional independence during this period of transition.

Another important focus in the questionnaire related to the students' perception of their role during supervised practice. Previous data demonstrate that during the practicum, individuals in both the student and client cohort, perceived the student in a practitioner role. Indeed, as previously described the aim of the practicum requires the student to undertake this role under the close supervision of the FWT. However, during supervised practice the student-supervisor relationship is different to that of the student-FWT; with the emphasis on assessment and support rather than



coaching. Although the ENB describe supervised practice as a period of professional development, I would suggest that many students perceive themselves primarily as a practitioner from the beginning of this period which has implications for the process of assessing competence in practice. Therefore the students were asked to describe their perception of the degree of professional independence apportioned to them during supervised practice. Only 3 (14%) described any perceived restrictions in their independence. 2 of these students had had the families with identified "problems" removed from their workloads. It is pertinent to note that one student interpreted professional responsibility in terms of families with acknowledged problems. She described herself having "as much as I wanted (professional responsibility) but obviously my caseload had been picked for non-problematic families' and there were few decisions to be taken". The other student was given her eventual workload with 'problem cases' removed. These were cited as a 'family with alcoholic parents, a family with two handicapped children, a one-parent family with an ESN mother'. She described her dissatisfaction with this situation, stating "I wish these had remained and guidance given on their management rather than being thrown in at the deep end". This evidence demonstrates once more the lack of an understanding and appreciation of professional artistry in the interpretation of professional practice by the supervisor during this period. The other student described herself as having complete independence, except for case conferences where there was full supervision.

However, the majority of the students described themselves as having professional independence during this time. Practice issues cited as examples were: running Child Health Clinics, home visiting,

organisation of workload, speaking at case conferences and developmental screening procedures following in-service training. However, it is significant that several of these issues were cited by the students when describing areas of practice in which they felt ill-prepared. They are also issues in which the intuitive knowing-in-practice of the practitioner in determining professional judgements is particularly significant. Interestingly, only 2 (10%) expressed any concern about their amount of independence. One student described feelings of anxiety stating "I felt I was given independence too soon - many days I found myself alone in the office - this seemed to occur when I desperately needed to seek advice". The other described herself as "being basically left to do as she pleased". Her concern related specifically to standards of practice. This is illustrated by the comment "I felt that if I had a weakness in any situation I can either avoid the issue or deal with the situation but I wouldn't know if I'd done the best thing. I felt I had to draw upon many skills that I had learnt prior to fieldwork". Nonetheless the predominant theme identified the range of professional independence given to the students. It varied from the student who described herself as having a great deal of professional independence commenting "one month into supervised practice my only health visitor colleague had two weeks annual leave and I covered both caseloads in this period", to the student who had experienced families with perceived problems being withdrawn from her workload. I would argue that these data not only demonstrate the variation in the practitioner role of the student during this period, but also the significance of developing an epistemology of practice from the reality of practice of which the concept of professional artistry is a fundamental descriptor.

It is interesting that although many students perceived their role as

primarily that of a practitioner, it is possible in the data to identify the methods used by the assessor in controlling the degree of independence in the student's practice. 2 (10%) were specifically requested to introduce themselves to clients as students throughout this time. One student demonstrated the conflict she experience with this situation by stating "we were not allowed to call ourselves health visitors till the qualifying date. I got round this by saying I would be the family's health visitor - because I felt the student status may interfere with the future relationship with the client". The other student, although her assessor had insisted she introduced herself as a student, did not experience the same conflict. She described her practice setting "as being allowed to act entirely independently wherever I was happy to do so...I was treated as a professional throughout". The students were also supervised during the Child Health Clinic sessions. 7 (33%) of the cohort described themselves being supervised, although once more there was considerable variation in the students' perception of this experience. One student described her assessor "sitting in on a clinic", whereas another stated "I did clinics with the proviso that a trained person was on the premises though no one listened to the advice I gave". However, I would suggest it is significant that only one student cited direct observation of her practice when commenting on professional independence. This student commented "I felt I was given quite a lot...I did not experience someone breathing down my neck at every move. I conducted my home visits on my own naturally and only had my assessor listening to me during two clinics" The implication within this comment is that it would be inappropriate for the assessor to visit with the student. However, I would argue that the lack of direct observation is equally significant in the process of assessing competence in practice during supervised practice as it

is during the practicum. The data demonstrate that although the students primarily perceive their role as a practitioner throughout this period of training, their interpretation of professional practice remains grounded in a traditional paradigm of maternal and child health. However the data also demonstrate features which can be summed up within the concept of professional artistry. Indeed I would argue that not only the interpretation of practice but also the students' interpretation of their role during this time as primarily a practitioner, has implications for their preception of the validity of the process used to assess their competence in practice during this stage of the course.

The students' perception of the validity of the methods used to assess their competence in practice

The assessment process must be completed by a practitioner who has undertaken a course for Assessors of Supervised Practice which has been approved by the ENB (Chapter 2:67). Those applicants wishing to participate in the course must either be a nurse manager with a health visiting qualification or have at least three years experience as a practising health visitor. The ENB require the course to last a minimum of 5 days . In the case-study college the course included a sixth day in which to evaluate the processes experienced in the period of supervised practice and a similar pattern is reflected in many other institutions. Although the course participants are not formally assessed, they are awarded a Letter of Attendance by the ENB. However, I would suggest this phenomenon raises a fundamental issue in the process of assessing competence in practice: the lack of procedures to assess the competence of the assessor. This issue must raise questions about the validity of the assessment process. The ENB define three functions for the assessor: a teacher, assessor

and counsellor (CETHV 1982). However at the time of the empirical work the majority of assessors were also the students' line manager thereby introducing a fourth role for the assessor. I would argue that for many assessors this may introduce a conflict in roles, particularly where there is a conflict in the interpretation of professional practice. This may also influence the students' perception of the assessment process. These issues therefore generated three specific foci in the data analysis:

- the students' perception of the time devoted by the assessor to the process of assessment,
- the students' perception of the purpose of the assessment procedure,
- the students' perception of the validity of the assessment procedure.

It states in the guidelines provided by the ENB that the student should meet regularly with her assessor. The data analysis demonstrated that this happened with the majority of the student cohort. The 1 (5%) student who had not experienced this practice commented that she would have found the exercise useful as it would have helped her "to completely understand what she (the assessor) was looking for". 17 (81%) met with their assessor on a weekly basis. The students' perception of the duration of the meeting ranged from 15 minutes to 2 hours. However, there was no correlation between the length of the meeting and whether the students described the experience as useful. Indeed only 2 (10%) actually described the meetings as useless, and in one instance the meeting was described as lasting 2 hours. One of these students related the judgement of "useless" to the fact that she shared an office with her assessor and therefore could talk to her at any time. However, the other quite

specifically stated that the meeting did not meet her expectations. She commented "I felt I needed 'every day' queries answered and that far-reaching questions about the 1974 reorganisation and where I felt I was heading in the long term was inappropriate". Therefore, I would argue that although the findings demonstrated the mismatch in perception of the purpose of the meetings, the predominant theme related once more to the range of the students' experiences. Certainly some students received very little input throughout the period of supervised practice. This finding not only questions the assumption that the assessor is acting in the role of teacher or counsellor but also raises the question as to the extent to which the assessor has the ability to assess the student's professional development.

When analysing the students' perception of the purpose of the student-assessor meeting 30 different criteria were identified. Table 9.2 demonstrates the frequency of those criteria cited by more than 3 of the students.

TABLE 9.2

Criteria stated for purpose  
of the meeting

For the student to discuss specific queries to health visiting practice	8
To inform the student of DHA policies	5
To provide the student with support and guidance	5
To offer the student constructive advice	4
To discuss the management of the caseload	4
To monitor the students' progress	3

N = 21

The frequency of the criteria identified for the student-assessor meetings cited by more than 3 of the student cohort.

I would argue that it is significant that the criteria relating specifically to assessing the student's competence in practice were less frequently cited. Indeed although the criteria could be clearly classified into four categories: teaching/facilitating, supporting managing and assessing, the greatest proportion of the criteria were identified in the first category. However, one student commented that her assessor "was eager to guide, though made a point very strongly that she was not there to teach". It is interesting that this student was the only one to acknowledge that she found the meetings stressful. Only 3 (14%) of the students stated that the meetings had not met their expectations. In two cases this related specifically to practice issues. One student commented "I had many missing records and angry clients and I felt that my assessor could have been more practically helpful during this time". I would suggest this finding highlights once more the significance of developing an epistemology of practice grounded in reflection-in-action. However, the predominant theme

demonstrated by those who had experienced the meetings as useful, related to the support and understanding of the assessor. One student commented "I found these meetings very useful, they increased my confidence, gave me moral as well as practical support and allowed me to develop my professional skills". I would argue these data not only demonstrate the different perceptions that individual students have of the purpose of the student-assessor meetings but also the variation in their perception of the role of the assessor. The majority of students considered the assessing role of the assessor secondary to that of teaching and supporting . Indeed I suggest this finding demonstrates that some students perceive this time as a continuation of the practicum rather than a period of transition which has implications for the students' perception of the validity of the assessment procedure.

Although the majority of the students described the assessment of supervised practice as a fair assessment of their health visiting skills, 8 (38%) expressed some concern about the procedure. It is significant that 5 of these students related this specifically to the lack of direct observation of their health visiting practice. One described her assessment as "very fair except for one comment which intimated that I was rather brusque and outspoken - I felt this was more an interpretation of how others see us...this was not based on client contact but on colleagues". This once more highlights the significance of client participation in the process of assessment, particularly in relation to the attitudes and personal attributes of the student. Another student particularly articulated her concern at the lack of direct observation stating "I felt it was a reasonably fair assessment of my health visiting skills but do not really see how you can be thoroughly assessed without your assessor accompanying



the student on visits". It is interesting that both the students who described the assessor-student meetings as useless were in this category. Indeed one actually stated "my assessor only came out with me on one visit and I feel this was insufficient to assess my health visiting skills". Two other students related their concern to the lack of time in supervised practice. One commented "I felt 3 months was too short a time for anyone to assess me fairly - at the end of 3 months I was just beginning to feel confident in my surroundings". The final student related her concern to the criteria on which the assessment was based commenting "I was told that all students were given the best grade unless they were really bad, however, I thought the comments were pertinent and said much more of reality" (1). I would argue it is significant that these concerns directly reflect those identified in the process of assessment in the practicum.

The students' perception of the assessment process identifies issues which must raise questions about the validity of the assessment procedures. However I would suggest other issues also effect the validity of the procedures. These issues include not only the interpretation of professional practice demonstrated by the assessor but also the management responsibility of the assessor, particularly if the student's performance is questionable. It is also significant that currently there is no requirement to assess the competence of the assessor, either in her role as an assessor or a practitioner. Indeed, I would suggest that the discrepancies in the students' perception of their experience during the assessment process reflects this problem.

The range of the interpretation of the students' role in the practice

setting during this period of transition is also highlighted. Indeed I would argue this finding must raise questions about the criteria employed by the assessor in judging the student's professional practice. It also raises the question of the extent to which the traditional paradigm of practice demonstrated in this period of transition is a result of the students' experience in the practicum or the demands of the assessor the supervised practice. The health visiting studies, prepared during the practicum but assessed at the end of supervised practice, provided the opportunity to explore this issue.

#### The Health Visiting Studies: the interpretation of professional practice and the implications for assessing competence in practice

The health visiting studies, another component in the final process of assessing competence in practice, were introduced in 1966 following the revision of the syllabus. This procedure consists normally of a study of two families or clients with whom the student has been working during the practicum. It also includes a study of the neighbourhood in which the families or clients live, taking into consideration both sociological and epidemiological factors and the implications for the health of the community. Although this procedure is considered an integrated piece of work, I would suggest that many students perceive the health visiting studies and the neighbourhood study as two separate assignments. Therefore for the purpose of my research I have explored the procedure as two distinct units and as the health visiting study has the most significance for the interpretation of professional practice this will be considered first.

The ENB states that the health visiting study should demonstrate the

student's ability to:

- "- extract information from relevant records,
- apply the information in determining priorities for work with the family,
- apply theory to practice in the development of health visiting skills,
- assess and if appropriate modify the health visiting plan,
- clarify the health visitor's role with the clients. It is expected that the studies should also demonstrate the student's developing professional competence and an awareness of self development in the health visiting role". (CETHV 1982:32).

Concern has been expressed by those involved in health visiting education (including external examiners), as to the extent to which the studies achieve the aims described above. Particular issues relate to the role of the FWT and the health visitor lecturer in the preparation of the study and the terminology used to describe the studies (HVATG 1982). The studies, in addition to health visiting studies, are referred to indiscriminately as case studies, fieldwork studies and family studies. This I would suggest demonstrates the absence of a coherent interpretation of professional practice. Indeed Fitton (1983) describes a case study as monitoring the events in a client's life without anticipating care or intervention which negates a fundamental aim of the studies. The collation of comments of external examiners suggested that "the proper terminology might help to focus attention on health visiting intervention " (Smith 1986:3). This report also identified the failure of students to relate theory and practice. Indeed a phenomenon which I would argue may not only be attributed to the reluctance amongst practitioners to develop and use a conceptual framework for practice, but also to the difference between the theory of health visiting and the reality of the practice

setting. This I would argue is a fundamental issue in the current use of the health visiting studies as a method of assessing the students' interpretation of professional practice. These concerns therefore raise questions about specific issues in the use of the studies in the assessment process in particular the extent to which the studies demonstrate the students' interpretation of professional practice and the role played by the FWT and lecturer in health visiting in the preparation of the studies. These issues will be explored using data acquired from three sources namely: the student cohort using the semi-structured interviews and the post course questionnaire, the FWT cohort using the semi-structured interviews and lecturers in health visiting using both the postal survey and the semi-structured interviews in the case study.

The extent to which the health visiting studies demonstrate the students' interpretation of professional practice

The students in the case study college are required to present two families or clients with whom they have worked during the practicum. Although this period of time extends during the academic year the ENB do not make any stipulation about the length of time that the student must have had contact with the clients. However the ENB do state that the studies should demonstrate "the student's developing professional competence and an awareness of self-development in the health visiting role, both in relation to the community and in the family context" (CETHV 1982:32). The studies should also demonstrate the student's ability in five specific areas of practice which have been identified earlier in the chapter (p. 350). However, I would suggest it is significant that the identification of these areas reflects a restricted rather than extended definition of professional practice, particularly as neither the concept of reflection-in-action

nor professional artistry is addressed either explicitly or implicitly. Indeed as previously identified the crisis in confidence in professional education has been specifically related to discrepancies in the interpretation of professional practice between educationalists and the reality of the practice setting (Schon 1987). Therefore these issues have implications not only for the interpretation of professional practice demonstrated by the student in the health visiting study but also for the validity of the study in the assessment process. When exploring the extent to which the studies demonstrate the interpretation of practice (and therefore implicitly the validity of the procedure) it is necessary to consider the perception of both the student and the assessor. The assessor in this context includes both the FWT and the lecturer in health visiting. The data were acquired from the postal survey and the semi-structured interviews in the case-study college.

The students were asked to describe their perception of the validity of the health visiting studies as a method of assessment, at two stages during the empirical work. The first stage was during the semi-structured interviews which occurred while the students were in the process of completing the studies (and therefore were actually involved in the practicum). The second stage occurred shortly after the students had successfully completed the course and involved the use of a confidential postal questionnaire (Appendix P). By exploring the students' perception at two different stages in their training, it provided the opportunity of identifying any changes which may have occurred in their interpretation of professional practice. However, unfortunately the first stage only included those students who had been selected to participate in the semi-structured interviews whereas the second stage included the total student

cohort.

In the first stage the students were asked specifically if they considered the health visiting studies a useful method of assessing their health visiting skills. 10 (83%) of the students responded positively and 8 of these students identified the studies specifically as a method of assessing their self development in health visiting practice; although some students expressed the findings in negative terms. This is illustrated by one student who commented "I think it demonstrates most of what you've done wrong - well my second study I wonder if I should put it in at all...I keep being encouraged that I should but I'm not a 100% convinced at this time...I might come round to the idea that I'm doing some good there by that time". Others quite specifically stated they used the studies to identify the gaps in their practice. One student described this by saying "There are things that I've felt while I've been writing - well I should have...you think why did I say that there and it is true it does come out...I loved doing them". The data also demonstrate the students use the studies to evaluate their health visiting role with the family. This is illustrated by a student's comment "Once you've got it down on paper and you have to think what have I done for this family you're able to say oh yes, I think that was quite good or no that wasn't too good". I would argue that it is significant that in the evaluation of the studies, the practice issues the students identified are particularly relevant to the understanding and appreciation of the concept of professional artistry. This is illustrated by one student writing:

"When I first met this family, I thought I might have  
difficulty forming an empathetic relationship with them..."

I was surprised and pleased to find we were able to exchange ideas. Some of the suggestions made by me were never put into practice, but nevertheless I felt the family were receptive and benefited from the support given"

Other students were less specific but identified skills such as communication and observation, which are factors directly influencing the student's ability to use her intuitive knowing in practice to inform professional judgements.

However other students although describing the studies as useful were much more negative in their comments. This is illustrated by one student saying "I think they are (useful) - as you have a written account of what you've done...you've had to take the trouble to find out what you should of done because otherwise you'll get clobbered...I think perhaps it's the gaps...the things you should have asked and didn't". It is interesting that this student, although from a negative perspective, is articulating the need to reflect on practice thus demonstrating an extended interpretation of practice. The 2 (17%) students who were negative about the use of the studies in the assessment process, related this specifically to the preparation of the studies. One stated she had found the studies "so boring to write"; the other described her feelings saying "because the two families - I don't think I've done anything with them - except give basic advice which I've given to all the other families - I don't think I've learnt any more by writing it up". Although I would suggest that these students are describing the learning process involved in the studies, rather than their validity as an assessment procedure, it is interesting that this confusion is

reflected throughout the data. However I would also argue that this statement demonstrates the student's difficulty in identifying the relationship between theory and practice which once more reflects the lack of a conceptual framework in the interpretation of professional practice.

When the total student cohort was asked to comment on their perception of the validity of the health visiting studies on completion of the course their response was more ambivalent. Although 10 (48%) still described the studies as a useful method of assessment, the students were less specific in identifying reasons. Factors such as self-evaluation and learning more by omission than inclusion were defined by individual students but the majority did not give specific reasons. However 3 (14%) students highlighted the fact that although the studies were useful, it was possible that students did not always describe the health visiting intervention offered to clients accurately. Indeed one student commented "They are a useful method although it must be said most are fact interspersed with a little fiction". Another illustrated this point stating "I think some people were very good at writing down what the examiner wishes to see - (it) does not illustrate a practical health visiting skill but a writing skill". I would suggest it is significant that this was also the predominant factor identified by those 7 (33%) students who responded negatively. They articulated their concern that although certain skills were described in the studies, they were not necessarily carried out in the work with the client. It is interesting that the issue of only demonstrating the skills used with 2 particular families was also identified. Those students who were undecided described the studies as useful learning tools but were uncertain about the assessment process. This is



illustrated by one student commenting "...very difficult to answer, I did feel they served a purpose but the fairly intensive visiting students make to their families seems a very false situation - however I did think I learnt from my studies although I'm not sure they were useful for assessing my health visiting skills". Although there is limited data available relating to changes in the students' perception of the interpretation of professional practice from the practicum to practice, I would argue it is significant that the data demonstrate the relevance attributed to the skills of the practitioner in the interpretation of practice. This task orientated client group approach to practice is also highlighted by the students questioning the validity of the studies as they only assessed their skills with two particular clients. I would argue that although this generally demonstrates a restricted interpretation of practice, it is significant that individuals within the cohort identified practice issues which specifically demonstrated a much wider interpretation of practice. Within these practice issues I would argue that the concept of professional artistry can be identified. However specific findings in the data, in particular the accuracy of the material, must raise questions about the validity of the health visiting study as a method of assessing competence in practice, as indeed must the role played by the FWT and lecturer in health visiting in the preparation of the studies.

#### The Health Visiting Study: its validity as a method of assessing competence in practice

The earlier discussion, identifying the involvement of the FWT and the lecturer in health visiting in the preparation of the health visiting study, raises an important issue which requires addressing

in exploring the validity of the study as a method of assessing the student's competence in practice. The FWT is responsible for selecting the clients who make up the student's workload and it is from this selection that the student chooses the clients to present in the health visiting studies. Therefore the FWT is directly involved in the initial stage of the health visiting study. However, I would suggest that further involvement of the preparation of the study is dependent not only on the FWT's interpretation of practice but also the student's perception of the standard of practice demonstrated by the FWT.

It is interesting that 6 (50%) of the student cohort in the semi-structured interviews had not requested any help from their FWT in writing their studies. Although in two instances the FWT had not initiated an offer of help, the four remaining students had actually not requested any help. The dominant theme related to the standard practice demonstrated by the FWT which included both high and low standards. One student commented "Oh, she wanted to - she wanted to be very involved in fact she's quite upset she's not going to get the chance to see mine in rough...but when we've talked about my families her ideas haven't been mine...certainly on visiting them there were (conflicting ideas)". This I would suggest highlights the influence of conflicting interpretation of practice on the effectiveness of the practicum. Another student demonstrated the anxiety caused by the high standards of practice in the FWT saying "I know it was mean to Joan but I just thought I couldn't do (it)... because she's so good and if she picked up something it was too late a stage (for me) to want to know about it". The predominant themes to emerge from those 5 (42%) students who acknowledged the help they had received from their FWT, related to the selection of families and the correction of

the studies. One student described the FWT's input as "-well just guidance really - if maybe I've written something which she feels is in the wrong place...I've just got her to look over them anyway - to see if there is anything I've done wrong in them". Another specifically described her FWT "correcting things" which she had thought were inaccurate. However another student expressed her ambivalence saying "I do feel able to ask her...the trouble is whenever I do ask her something like that she goes overboard about it...I'm not sure she knows quite what we're supposed to be writing...". However, the influence of the FWT's practice in governing whether the student requests help in the preparation of the studies is illustrated in Table 9.3.

**TABLE 9.3**

<b>Student</b>	<b>FWT perceived as a role model</b>	<b>Request for help with health visiting studies</b>
28B	Ambivalent	Yes
14B	No	No
10B	No	No
16B	Ambivalent	No
8B	Yes	Yes
3B	Ambivalent	No
23B	No	Ambivalent
21B	Yes	Yes
25B	No	No
12B	Yes	Yes
19B	Yes	No
18B	Yes	Yes

The Relationship between the students' perception of their FWT as a role model and requesting help with the preparation of their health visiting studies.

I would argue it is significant that there is a correlation between those students perceiving their FWT as a role model and requesting help with the preparation of the health visiting studies. I would argue this finding demonstrates the influence of the FWT in the preparation of the study which I would suggest has implications for the validity of the assessment procedure.

All the student cohort agreed that the tutor (a lecturer in health visiting) should be involved in the preparation of the studies. The predominant theme related to the need for the students to receive reassurance and guidance, particularly as the preparation of the study was perceived as a learning experience. One student described her feelings saying "I'd never be able to do them if I didn't get that help - no you're not doing the work for us - you're just opening up avenues and explaining things". Another student's observation particularly related to the validity of the assessment process. She identified the students' interpretations of the different requirements for the studies made by individual tutors commenting "I've asked for help - I've found it very conflicting having dealt with two people ... students quote what one tutor said and that caused a lot of conflict". However 3 (25%) of the students expressed concern about the help that was offered by the tutor. The issues identified related particularly to the students' perception of the author of the work as well as the possibility of the work being fictitious. One student described her feelings saying "I think the whole thing of studies is a bit of a farce - you could spend all the time doing it again - taking it back to your own tutor getting it better and better - by that time it's not yours is it?" Another commented "...I read one family study done on a family I had met and

I thought it was a different family...you do get encouraged to miss out bits that are going to be complicated in your viva..." Indeed this evidence must raise questions about the extent to which the interpretation of practice in the study, reflects the reality of the practice setting. One student expressed her conflict about the amount of help some students received saying "I think I feel faintly annoyed that a lot of people get a lot of help..." I would argue that the data demonstrate the phenomenon of 'cue-seeking' identified in Chapter 2, which has implications not only for the interpretation of professional practice presented in the study but also for the assessment process.

When the FWT cohort were asked to describe their perception of their involvement in the preparation of the studies in the semi-structured interviews, only 3 (25%) gave an unqualified positive response. One related her involvement to personal satisfaction stating that it made the experience of working with a student more interesting. However another explicitly related her involvement to her concern about the student's ability to successfully complete the studies saying, "I felt with Linda, because this is going to be a difficult area for her, she would need more guidance than other students...because she's been able to demonstrate her knowledge gained to me then I feel I must say look you haven't written this...'. This I would argue explicitly demonstrates the influence of the FWT not only in the interpretation of practice but also in the assessment procedure. Another 5 (45%) qualified their response with the word "only", stating specifically that they left it to the student to initiate the request for help. Indeed one FWT commented "...only when I've been asked - I do feel it should be their own work...I did resent with one student having to correct it almost like an essay because I do feel

it should be their own work". However, in others the reservations related to the type of help offered to the student. The FWTs' role in the selection of clients presented in the studies emerged as the predominant theme. One FWT described her involvement saying "in selection - because I didn't agree with her initial selection and we discussed it and she eventually changed her mind...". Another objected to the student's selection because "...she (the student) wanted to choose the family she got on with best...I felt she should have families which used very different skills...". However this evidence raises the question of whether the student had extended her interpretation of professional practice to include an understanding and appreciation of the concept of professional artistry which had been misinterpreted or indeed unrecognised by the FWT. Although 4 (33%) of the cohort had not been involved, only 1 ascribed this to the fact that she had not been prepared to help saying "I don't really feel my knowledge is up to it...actually I feel the student knows more about the families than we do because how can you do that amount of visiting?" This evidence has serious implications for the effectiveness of the practicum, particularly in relation to the FWT's ability to develop an epistemology of practice grounded in reflection-in-action.

I would argue therefore that individual FWTs have very different perceptions of their role in the preparation of the studies. Indeed I would suggest it is significant that 2 FWTs had a totally different perception of their involvement to that of the student. This is particularly pertinent if the student's competence in practice is doubtful and must raise the question of whether the assessment procedure reflects the student's ability, or a significant contribution from the FWT or lecturer. However I would suggest

another significant finding in the analysis identified the concern expressed by the FWTs, that the students' study would reflect the FWTs' competence in practice. 5 (45%) of the FWT cohort identified factors which specifically related to this issue which is illustrated by one FWT's comment "I usually read through - I don't think I'd like there to be any inaccuracies concerning myself particularly". I would argue this finding is particularly significant where there is conflict in the interpretation of practice between the FWT and the student.

The discrepancy in the FWTs' contribution in the preparation of the studies was also a predominant theme in the data obtained in the postal survey circulated to lecturers in health visiting. Only 2 (11%) lecturers described the FWT as having minimal involvement. Although in one instance this was related to the lack of motivation in the FWT, in the other it specifically related to the requirement of the institution. The lecturer commented "this institution specifically state that FWTs can't be involved in the writing of studies...they should be prepared to discuss with their students situations as and when they arise". The remaining 16 (88%) identified some FWT involvement which could be classified into five categories of intervention:

monitoring, both the student's performance and the accuracy of content,  
the selection of clients from the students' work load,  
reading the studies,  
correcting the completed studies,  
providing a learning experience for the students.



The factors which influenced the extent of FWT involvement were identified as; the commitment of the individual FWT, the FWT-student relationship and the student initiating a request for help. Although the lecturers acknowledged the help given by FWTs, the predominant theme related to the studies being seen as the students' own work. However one lecturer described her feelings stating "rather than feeling it's not the student's own work - I worry sometimes they haven't got enough help in working on their studies and also that the interaction between the FWT and the student isn't recorded in the studies, because a lot of the decision making process and the learning goes on or should go on, in discussion between the FWT and the student". This highlights the significance that some lecturers attach to the interpretation of professional practice demonstrated in the study. Indeed I would argue that this finding also demonstrates the expectation that this interpretation is implicitly grounded in reflection-in-action. However the obvious discrepancy in the lecturers' expectation in the degree of involvement by the FWT in the preparation of the student's studies, must raise the question of the validity of the study in the assessment process. Indeed it must also question the extent to which the individual lecturers' interpretation of professional practice effects the validity of the procedure.

It is interesting that similar discrepancies were demonstrated when exploring the tutors' perception of their own involvement in the preparation of the studies. The tutorial help ranged from "fortnightly tutorial discussion on previously read material" to an arrangement of "as and when appropriate", with the student having the responsibility for seeking help in preparing the studies. However, in some institutions tutorials were described "more or less compulsory early in the course". This I would suggest raises the

additional issue of the extent to which the lecturers acknowledge the particular needs of adult learners. The format of the tutorial help also varied considerably. Interestingly, 4 (22%) of the tutor cohort stated that the study which had been discussed in tutorials was considered specifically a learning experience and therefore could not be submitted for assessment purposes. However, another tutor's description of her role in the preparation of the studies could be interpreted as one of correcting the student's work. This is illustrated by the comment "individually I ask the student what she thinks she has done with the clients and tell her whether this is clearly stated in the study". It is significant that the discrepancy in tutorial help was also identified from the data obtained from the lecturers in the case-study college, which highlights the range of help and expectations presented in one institution. Indeed one tutor described her feelings commenting "well I'm in a fix here because the student runs round between the FWT, anyone else who is available in the field, the tutor who runs the health visiting study group, the tutor who runs the applied health visiting group, so she runs from one to the other...they get so many inputs that I have to say to some of my students - well make up your mind whose advice you're going to take and stick to it". Therefore I would argue that the data not only demonstrate the significance of the interpretation of professional practice in the presentation of the material in the study, but also the discrepancy in the type and amount of tutorial help which is offered to students. Both these issues must raise questions about the validity of the study in assessing the students' competence in practice.

Although the data obtained from the postal survey demonstrated that 9

(50%) of the lecturer cohort considered the health visiting studies a valid method of assessing the students' practice, it is significant that once more the emphasis on a task orientated approach to practice was demonstrated. However it is pertinent to note that of those 8 (44%) respondents who expressed concern about the use of the studies, the predominant theme related to the extent to which the assessment process was biased towards the student's academic ability. This is illustrated by the comment "(the studies) do show an ability to give continuity of care, planning, appropriate referrals - all of this is influenced by the student's ability to express herself through the written work which limits their value". Nonetheless, other reservations included the support provided by the FWT, the degree to which the study was a true reflection of practice and the difficulties created by the subjectivity of the students' self-evaluation of health visiting intervention. Indeed it is interesting that only 1 (6%) respondent was negative in her comment describing the study as an "excellent teaching tool but limited in its scope for assessment".

The reservations identified in the general comments about the health visiting studies, occurred once more when the cohort was asked specifically to state any concerns they had in using the studies as an assessment tool. Although 12 different factors were identified as causing concern, those cited by more than one respondent were:

- the studies should not stand alone as a procedure,
- whose work was being assessed - the FWT's the student's or the lecturer's?
- how much the student has adapted the study in the writing up.
- the influence of the student's academic ability.

I would argue it is significant that these findings not only reflect

those of the student and FWT, but also that these issues directly influence the extent to which the health visiting studies are a valid method of assessing the students' competence in practice.

Therefore although the findings demonstrate explicit concern amongst a significant proportion of the respondents about the validity of the health visiting study, I would argue that the findings obtained from the other respondents are equally significant. Indeed these findings clearly identify the emphasis placed on an epistemology of practice grounded in a model of technical rationality by respondents in each of the cohorts. This once more highlights the lack of significance associated with the understanding and appreciation of professional artistry in attaining competence in practice. It is also pertinent to note that despite some evidence to suggest that the health visiting studies demonstrate a degree of validity as a method of assessing competence in practice in relation to the demands of the ENB, this emphasis on a traditional epistemology of practice raises serious doubts as to their validity as a method of assessing competence in practice. Indeed I would argue these findings contribute to the crisis in health visiting education, particularly in relation to the difference between the theory of health visiting and the reality of the practice setting. It is also significant to note that only 1 of the 32 respondents in the assessor cohort made any reference to the client's perception of the health visiting intervention offered by the student during this period of time, despite the studies being supposedly centred in the reality of the practice setting.

As previously discussed the neighbourhood study forms an integrated piece of work with the health visiting study. Therefore the

significance of this piece of work to the interpretation of professional practice and also assessing competence in practice also requires addressing.

### The Neighbourhood Study

The ENB describes the purpose of the neighbourhood study as demonstrating "the needs and the health visiting priorities, including the stimulation of self-help and support groups, in the area studied" (CETHV 1982:31). It should also include an analysis of the sociological and epidemiological factors within the defined area thus providing the social context for those families presented within the health visiting studies. Criticisms have been made of the use of the neighbourhood study as a means of assessing the students' competence in health visiting (Hunt 1982; HVATG 1982). Issues surrounding the use of the neighbourhood study have also been debated at the annual meetings of external examiners in health visiting (Smith 1985). These issues particularly included: the presentation and use of statistical data, the use of a caseload profile and the effect of District Health Authority policies on practice. Unfortunately, within this present study the FWTs and the lecturers were not asked to comment specifically on the neighbourhood study. However 2 (15%) FWTs raised the issue spontaneously in the semi-structured interviews. Therefore the responses of the lecturers and the majority of the FWTs refers only to the health visiting studies. Nonetheless, I would suggest this in itself is a significant phenomenon (as previously discussed): the ENB guidelines describe the Neighbourhood Study and health visiting studies as an integrated assignment. Indeed it is interesting that of those students involved in the semi-structured interviews 4 (33%) introduced the topic of the neighbourhood study and did not identify

any distinction in the studies.

However, in order to clarify the distinction between the two studies the final questionnaire circulated to the students included an explicit question on the neighbourhood study. The students were requested to describe their perception of the usefulness of the study as a means of assessing their health visiting skills. The data obtained were used to analyse their interpretation of practice. Once more the students were divided in their response, with 6 (29%) responding positively. The predominant theme related to the need to assess the student's ability to identify factors within the neighbourhood, which affected the health status of an individual or the community. The study was also identified as a means of assessing the student's ability to search for information. However 10 (48%) of the students, although acknowledging the use of the study, expressed some reservations. The predominant theme related to the fact that the study was considered of more use to the student personally than as an assessment tool. This was illustrated by one student's comment "Although not really enjoyable to write, it does allow the student health visitor to assess differences in areas - I think that the student learns more from them than the tutors learn about the student". Another described it as "useful in helping me to develop an awareness of the area and information sources". Other concerns identified by the students included the possibility of students "rehashing those that had gone before", the amount of time "wasted" as the students would not be working in that area once qualified and the amount of tutorial help provided. It is interesting however, that the concerns expressed by 2 students directly demonstrated their interpretation of professional practice. The study was described as useful because it meant "that one learns how to research an area to

find resources" and because "it showed how one collated and used data". However both these students (who were academically able) failed to correlate these concepts with the search for health needs previously identified as a fundamental principle in health visiting (CETHV 1977). I would suggest this evidence once more highlights the need for a conceptual framework in practice.

The 5 (24%) students who were negative in their response, identified similar factors to those students who had demonstrated their ambivalence to the study. The issues of wasting time, using information from previous studies and being more appropriate as a method of assessment in supervised practice were identified. It is interesting that these students related their comments to the use of the study to them personally, rather than as an assessment tool as was requested in the questionnaire. The one student who attempted to comment on the validity of the neighbourhood study as a method of assessment remarked "It would seem that neighbourhood studies are sometimes handed on from year to year therefore I feel it's possible to present an impressive study without any real development of health visiting skills taking place". I would suggest this evidence highlights the difficulty in identifying the students' interpretation of professional practice as presented in the study.

When the students were asked to identify methods of improving the validity of the neighbourhood study as a method of assessment a similar pattern was seen. The majority of the responses related to factors which affected them personally such as the study being undertaken during supervised practice, although it is interesting that 12 (57%) of the cohort failed to respond to this particular question. Two issues which were identified however, were the use of

a caseload profile and the in-depth study of a particular aspect of the defined neighbourhood. It is significant that Hunt (1982b) describes the use of a caseload profile as a method of evaluating health visiting practice. Indeed one student described her feelings about the study commenting "The health visitor does have a responsibility to find out the rates (morbidity/mortality) for her area and the neighbourhood study did make each student do this - however whether they're aware of each rate in their own area now is highly unlikely - therefore I don't honestly feel the study is related to practice but becomes a piece of work that must be handed in". Nonetheless I would suggest these data once more demonstrate the difficulty of using the study to identify the students' interpretation of practice.

Therefore I would argue that the data demonstrate not only the difficulty of using the neighbourhood study as a method of interpreting professional practice but also of assessing competence in practice. It is interesting that some students articulated their doubt about the validity of the procedure. This particularly related to information and help being acquired from different sources which once more was perceived as influencing the authenticity of the material presented. As data are not available from either the FWT or lecturer cohort it is impossible to identify any recurring themes as in the health visiting studies. Despite this situation I would suggest that the use of the neighbourhood study in identifying the students' interpretation of professional practice presents similar concerns to those of the health visiting studies. This therefore is an issue which requires addressing in much greater depth.



### The Oral Examination

The oral examination was used as a method of assessing the students' competence in practice prior to introduction of the revised syllabus in 1966. Although the method of assessment was retained following the implementation of the present course, the basis for the oral was changed. Batley (1979) describes the earlier format of the oral as one which used hypothetical situations to demonstrate the student's ability to apply theoretical knowledge to a practical situation. The current Regulations clearly state that the health visiting studies provide the basis for the oral examination. However at the time of the empirical work it was possible for a student to be referred in the oral examination despite achieving a pass grade in the health visiting studies. This anomaly has been recognised by examiners and raises questions about the validity of this procedure in assessing the students' competence in practice. Those involved in health visiting education have also questioned whether the oral examination should stand as a procedure in its own right rather than as a confirmatory process (Smith 1986).(2) Indeed Ray (1986:3) questions both the validity and the purpose of the oral examination stating:

"There seems to be little agreed protocol about the type and nature of the questions to be asked. Examiners, both experienced and inexperienced, can fall into the easy trap of trying to teach the student or to use this viva time as a chance to air their pet hobby-horse or theme". She goes on to discuss the subjective nature of the oral procedure, citing both the personality and the verbal fluency of the student as factors which affect the validity of the procedure. However it is significant that when National Standing Conference was provided with the opportunity of amending the requirement for an oral examination in the revised Regulations, those

present voted to maintain the status quo without recommending any further research into the subject (Strehlow 1987). Within this present study I have only considered the students' perception of the oral examination and the data were obtained from the confidential questionnaire circulated on completion of the course.

The responses obtained from the questionnaire could be divided into two main categories: the purpose of the oral and whether it was useful in assessing competence in practice.

**TABLE 9.4**

**The purpose of the oral examination**

Expand on material in the health visiting studies	10
Clear up any queries from the written paper	4
Knowledge of health visiting practice	3
Safe to Practice	3
To demonstrate the student's ability to communicate	2
To demonstrate student's ability to cope with a stressful situation	2
To reappraise the health visiting skills since their completion prior to supervised practice	2
To show an understanding of the work in the health visiting studies	2
To demonstrate the development of health visiting skills since completion of the health visiting studies	1
The College's final chance to reject the student	1
To assess whether the student's personality and manner are appropriate	1
To discuss the ways of assessing clients and their needs	1
To assess the student's attitude to health visiting	1

**N = 21**

**The Student's perception of the purpose of the oral examination**

**(\*Some students gave more than one reason)**

Table 9.4 demonstrates the range of items cited by the students when describing their perception of the purpose of the oral examination. I would suggest these data support not only the concern expressed by Ray (1986) about the type of questions actually asked by examiners, but also raise questions about the extent to which the oral examination is used to identify the students' interpretation of

professional practice. Indeed although 15 (17%) had identified the health visiting studies as a focus for the oral, only 10 (48%) explicitly described the purpose to discuss the health visiting intervention demonstrated in the studies. It is interesting that the majority of the students had identified at least two purposes for the oral examination. Within this group 6 (29%) had included their competence to practice, with one student specifically describing the oral as "the College's final chance to reject you". This I would suggest demonstrates that some students perceive the oral as an examination which can be passed or failed in its own right.

In analysing whether the students perceived the oral as fulfilling the purposes they had described, their responses could be divided into four categories: positive, qualified, negative and uncertain. Only 8 (38%) gave a positive response and I would suggest it is significant that only three of this group had cited discussion of the health visiting studies as a purpose of the oral. Of those 5 (25%) students qualifying their response, one identified concern that no reference had been made to the written examinations and another that the decision about the student had been made prior to the oral. The predominant theme of those 5 (24%) students expressing a negative response related to the time of the oral. The issues of the examiners not having adequate time and too much material were both identified. Indeed one student described her feelings saying "I was panicked by the slow pace and conversational examining and did not feel able to be conversational in return - also I did not realise I could argue for or against things I or the examiner had said - I felt very stilted and confused by it". I would argue this finding once more raises questions about the validity of the oral as a method of assessing not only the students' interpretation of practice, but also

their competence in practice.

It is significant that one student expressed her concerns stating "only the client is going to know how good your skills are in the practical situation". This once more highlights the importance of the reality of the practice setting. The predominant theme of those 7 (33%) students who considered the oral useful, related to the fact that the outcome was not dependent on their academic ability. One student described the oral as "very useful - it gives one a chance to prove one's skills especially if written work is not your forte". Interestingly another identified its use for the borderline student commenting "If you're borderline on certain points then to talk these over sometimes helps - some people can express themselves better verbally than in writing". However I would argue that although the oral examination may provide a useful additional means of assessing the students' interpretation of practice when their competence is in doubt, the previous discussion demonstrates that the questioning technique of the examiners needs careful consideration.

When the students were asked if they had experienced the oral as a stressful situation 8 (38%) of the cohort answered positively. The predominant theme related to the uncertainty of the procedure. The students used phrases such as: "working out what the examiners wanted to know, not sure what they were getting at, a casual chat, almost like an interview" to describe their feelings about the procedure. The personality of the examiner was identified as the predominant theme by the 12 (57%) students who did not consider the procedure stressful. The examiners were described as both "relaxed and friendly" and "charming". The students also identified the format of

the oral, describing it as more of a discussion than direct questioning. However, it was also possible to identify factors relating to the examiners and the procedure which I would suggest, have particular relevance for the validity of the procedure if the student's competence in practice is in doubt. Factors such as the examiners being very tired, the noise from outside the examination room making questions indistinct and the variation in time allocated to individual students are examples which demonstrate the subjective nature of the oral examination. Indeed I would suggest these findings must raise questions about the validity of the procedure particularly when assessing the competence in practice of the borderline student.

Therefore although the oral has been identified as a means of examining the students' competence in practice (using the material presented in the health visiting studies), I would suggest that the oral is not primarily perceived by the student as a method of assessing their interpretation of professional practice, nor more significantly as a method of identifying any change in their interpretation of practice in the transition from practicum to the practice world. However it is significant that the data clearly demonstrate issues questioning the validity of the procedure, in particular the subjectivity of the process. Factors such as the personality of the examiner, the time allocated to the procedure for individual students, the physical environment and the method and complexity of questioning emerged from the data. Although I acknowledge the data only represent the students' perception of the process, these findings support those concerns expressed in the literature and I would suggest raise questions about the validity of the oral as a method of assessing the students' competence in

practice.

### Conclusions

The ENB consider the period of supervised practice one of transition which allows students, through their professional development, to adapt to the demands of the reality of the practice setting. However the findings demonstrate throughout this period, an interpretation of practice grounded in a model of technical rationality. This once more not only negates the fundamental role of the intuitive knowing-in-practice which informs and determines professional judgement but also the ability to reflect-in-action: both fundamental to meeting the demands of the reality of the practice setting. In addition the findings raise questions about the extent to which the period can be considered one of transition. This not only relates to the length of time but also to the fact that some students from the outset, experience practice situations which demand competence in practice equal to that of the qualified practitioner. However others continued to practice throughout the period in a protected environment which reflected the practicum, thereby questioning the opportunities provided for the student to extend their professional development. It is particularly significant that the findings demonstrate the different expectations of the assessors and the students and indeed highlight the practitioner role undertaken by some students throughout this period: findings which have implications for the validity of the assessment process.

The data demonstrate that the students' interpretation of professional practice throughout this period remains grounded in a traditional paradigm of maternal and child health and indeed

continues to reflect the difference between the theory of health visiting and the reality of the practice setting. However I would argue that it is significant that those practice issues in which the students considered themselves poorly prepared, are issues which are particularly dependent on the intuitive knowing-in-practice demonstrated by the practitioner in the determining of professional judgements. This I would suggest demonstrates an implicit acknowledgment of the significance of the concept of professional artistry in competent practice. Indeed I would suggest it is significant that the students identified this as an area of deficiency within their professional preparation in both the practicum and supervised practice. In addition I would suggest that this interpretation of practice grounded in a paradigm reflecting a task orientated, client specific approach to practice demonstrates the students' inability to employ a conceptual framework in the interpretation of practice. Once more these findings have implications for the process of assessing competence in practice.

Therefore the findings not only raise questions about the students' interpretation of professional practice during this period, but also about the validity of the procedures used to assess this interpretation. The use of work prepared during the practicum with an input from both the FWT and lecturer must raise questions about the authenticity of the students' interpretation of practice presented in the material. Indeed I would suggest this phenomenon raises particular questions about the role of the assessor, in material which is used directly as a means of assessing the students' competence in practice. The findings raise further questions about the role of the assessor generally during this period of transition. Not only is there no requirement for this individual to demonstrate



her competence as an assessor or practitioner, but for the majority of students this individual will also be their manager. This I would suggest may have significant implications in the interpretation of professional practice presented by the student during this time. In addition the findings highlight the subjectivity in the processes involved in the oral examination and in particular question its validity in assessing the students' development in professional practice. Indeed I would argue that the data not only raise serious questions about the validity of these procedures as a means of assessing the students' competence in practice but also as a means of assessing the students' interpretation of professional practice.

- (1) At the time of the empirical work the ENB procedures for assessing competence in practice during supervised practice used a system of both rating scales and comments. (Appendix A)
- (2) The revised regulations currently in use require that the oral, the health visiting and neighbourhood studies and the report from supervised practice are considered as a single component.

## Chapter 10

### Assessing an art form: a new approach to the assessment of competence in health visiting practice

#### The need for change

The crisis in confidence in health visiting has not only occurred in those individuals on the periphery of practice, whose criticisms could be challenged legitimately from within the profession, but also more significantly in the consumers of the service and indeed practitioners themselves. Goodwin (1988:2) describes the demands of current practice leading to "a routinized, mechanistic and even mindless, checklist ticking approach to health visiting with the only measurable products being a head count of individuals visited or seen". She goes on to identify practitioners "trapped in a narrow and restrictive straight jacket of health visiting practice", highlighting the inappropriateness and inhibiting nature of the traditional approach to practice; a criticism also identified in the recent review of the community nursing services (DHSS 1986).

Although current issues in the profession, such as the recent child death inquiries, the introduction of Griffiths style management, and the implementation of the Korner Report (1982), have highlighted the crisis in confidence and the need to reconsider professional practice, the phenomenon is not new to the profession. As previously discussed, Robinson (1985: 69) describes a mood of "self doubt within the maternal and child health services" apparent over a decade ago. This I would suggest has in part contributed, to an emphasis within

the profession, of defining the appropriate skills and professional knowledge for practice rather than questioning the validity of conceptual origins of health visiting strategies. Indeed I would suggest that the medical model of child health surveillance - based on the theory that the repeated application of screening tests and checks is the most appropriate method of detecting abnormalities in a child's development (despite the lack of conclusive empirical evidence, (Hall 1989)) which is practised by many health visitors, substantiates this view. This preoccupation in defining appropriate skills and knowledge has contributed to a conflict in basic beliefs within the philosophy of health visiting: a belief that the concepts of health visiting can be operationalised, measured and quantified and therefore made scientific, versus a belief that the concepts are unique and particular to each individual situation and therefore implicitly associated with the artistry of practice. It is the polarisation of the interpretation of practice which I believe has contributed to the current crisis in the profession.

However I believe that another major factor contributing to this phenomenon in health visiting is the gap between the theory of health visiting and the reality of the practice setting. Indeed an interpretation of practice which continues to advocate a traditional paradigm grounded in maternal and child health must raise questions about the conceptual origins of health visiting strategies, particularly as health data demonstrate that the most significant threats to public health are currently coronary heart disease, cancer, alcohol and drug misuse, and increasingly HIV infection. Undoubtedly these changing health issues highlight the need to develop an epistemology of practice grounded in the reality of the practice setting and developed from the process of

reflection-in-action. This concept has been identified by Schon (1983), who argues that practitioners have the ability to reflect on their intuitive knowing whilst in the midst of practice and therefore by using protocols of actual performance in practice it is possible to construct and test models of knowing in practice. The processes involved in this approach to an epistemology of practice, enable the practitioner to not only adapt her practice to the changing needs of the professional context but also to continually appraise performance in practice; processes which are fundamental for the development of a reflective practitioner.

It is within this framework that an understanding and appreciation of the concept of professional artistry emerges as an essential process in determining competence in professional practice. The knowing-in-practice by which practitioners handle the value conflict, uniqueness, and complex situations in the practice setting and the intuition used to make sense of that practice situation in making professional judgements, is fundamental to the development of an epistemology of practice which reflects the changing context of professional practice. This concept is supported in health visiting by Robinson (1987:22) who, as previously described in Chapter 1, argues that the uncertainty in practice has resulted from practitioners displaying an over sophistication in the search for a theoretical base, whilst demonstrating a reluctance to acknowledge the importance in practice of characteristics described as "non-judgemental, empathetic and relating on a moment to moment basis". Indeed, as I have demonstrated earlier, Robinson (1982) specifically argues the need for practitioners to perceive practice as both an art and a science. She relates this concept to the paradigms of health visiting she describes as relationship-centred

and problem-orientated. She goes on to argue that these are not mutually exclusive but must be considered simultaneously when examining health visiting practice. However although an appreciation of the concept of professional artistry is fundamental to the process of professional judgement, I would argue it is the most complex element within professional practice and as such contributes to the phenomenon of the inconsistency between the theory of health visiting and the reality of the practice setting.

The concept of professional artistry: the implications for determining competence in practice

Indeed, it is the discrepancy between the real world of practice and that of professional knowledge which has contributed to the crisis in professional practice and has necessitated the redefining of competence in practice. The traditional model of technical rationality, based on a process of instrumental problem solving, using and applying scientific theory and techniques, negates the concept of professional artistry. This allows professionals to attempt to fit practice situations into professional knowledge by either ignoring issues which do not correspond to defined categories or trying to force the situation to conform to available techniques. This approach to an epistemology of practice is no longer acceptable in a professional world where clients are put at risk and incompetence in practice is apparent. This is why I would argue consistently that the evidence demonstrates the need to develop an epistemology of practice which acknowledges the fundamental role played by the concept of professional artistry in determining competence in practice. However the evidence also demonstrates that this issue is negated by those in health visiting education who continue to employ a process of assessing competence in practice

grounded in a model of technical rationality.

Within the current context of health visiting the epistemology of practice is directly influenced by that implicit in the procedures used to assess competence in practice. This highlights the significance of the interpretation of professional knowledge by the assessors, in particular the lecturers in health visiting who play a major role in designing the assessment process. Indeed, although the lecturers identified the restricted learning experience of the practicum as a factor influencing the validity of the assessment process, I would argue it is significant that their interpretation of practice was also grounded in a traditional paradigm. This highlights a task orientated approach directed at specific client groups rather than one grounded in the principles of health visiting or the political dimension thereby indicating a conceptually-originated paradigm of practice. However, even within this traditional paradigm the conflict experienced by lecturers in their understanding of a particular theory of the nature of professional practice is demonstrated. Although the data highlight practice issues grounded in a model of technical rationality, the significance of an appreciation of the concept of professional artistry is clearly identified. The lecturers repeatedly identified practice issues such as the use of interpersonal skills, self awareness and intuitive knowledge in making professional judgements. In addition the importance of the student's ability to cope with emotional factors such as anger, unhappiness and bereavement were particularly identified. Despite the evidence illustrating the importance attached to an appreciation of the concept of professional artistry, it is significant that this concept is not considered a legitimate criterion for questioning the student's

competence in practice and therefore failing the student.

The lecturers' perception of the use made specifically of intuition in the assessment process, also highlights the conflict experienced in the interpretation of competent professional practice. Despite the well documented arguments demonstrating the role of intuition in forming professional judgements (England 1986, Schon 1987), the lecturers' identified particular concern in the FWTs' use of intuition in assessing the students' competence in practice. Although this particularly related to the possible confusion between intuition and subjectivity, I would argue it highlights the prejudice demonstrated by practitioners in the use of intuition in professional practice. This supports the evidence presented by Schon (1987) which suggests that, within a taxonomy of practice components, practitioners dismiss intuition as a 'junk category'. However, it is pertinent that the significance of the use of intuition was acknowledged in assessing the students' attitudes and ability to communicate; issues implicit in the process of making professional judgements and therefore competence in practice. Therefore although the data demonstrate the significance of the concept of professional artistry in the interpretation of practice, this is not acknowledged in the assessment process. Indeed greater substance is attached to the required knowledge and skills which once more demonstrates an epistemology of practice developed from a traditional grounding in technical rationality. It is evidence such as this which contributes to the gap between the theory of health visiting and the reality of practice.

The FWT, although constrained by the epistemology of practice implicit in the procedure, not only has the primary responsibility

for assessing the students' competence in practice, but also as the evidence highlights, plays a significant role in the student's interpretation of professional practice. Therefore it is significant that the data demonstrate an interpretation which not only highlights a traditional paradigm grounded in maternal and child health (with little acknowledgment of proactive health promotion), but also an emphasis on technical training using an apprenticeship model. The adoption of this approach inhibits the student from exploring and developing the forms of inquiry which enable the practitioner to adapt their professional knowledge to the unique demands of the practice setting. It is also significant that despite the FWTs recognising the importance of the concept professional artistry in practice, this was once more negated in the assessment process. Therefore although the FWTs' theory of the nature of professional practice reflected that of the lecturers in health visiting (a phenomenon which I would attribute to the emphasis currently given in the assessment process to the theoretical component of the course), I would argue once more that the FWT's interpretation has particular significance for the student. This relates specifically to the concept of role modelling and suggests that unless the conceptual origins of health visiting strategies are addressed, practitioners will continue to develop an epistemology of practice divorced from the reality of the practice setting.

The significance of developing an epistemology of practice grounded in the reality of practice was also apparent in the evidence obtained from the client cohort. Although the clients acknowledged the role of professional knowledge in the form of advice and information giving, the predominant theme in their interpretation of practice identified the giving of support in the form of listening, acting as



a 'sounding-board' and responding to the expressed needs of the client. Indeed the importance and value attached to listening by the practitioner is demonstrated throughout the data. However, the significance of the attitudes and attributes of the practitioner in influencing the effectiveness of the practice outcome was also clearly identified. However, I would argue it is significant that although clients spontaneously described feelings of liking or warmth towards the practitioner, the clients acknowledged that this alone did not constitute competence in practice, thereby demonstrating the fundamental role of the intuitive knowing in practice by which the practitioner handles the practice situation. The evidence also demonstrates that the majority of clients did not attach greater significance to the science of practice. This therefore undoubtedly indicates that the interpretation of practice must simultaneously consider the paradigms of art and science if the criteria for competence in practice demanded by the clients are to be met.

Although the client cohort described a traditional paradigm of health visiting grounded predominantly in child health, reflecting that of the FWTs and the lecturers in health visiting, the data demonstrate the inconsistency between the clients' and practitioners' interpretation of practice. This specifically related to the clients' demand for the practitioner to give equal consideration to the art and science of practice. It is also significant that despite client participation in the learning experience provided in the practicum, health visiting education has not resolved the dilemma of the gap between the reality of the practice setting and the theory of health visiting. Although I would argue this in part can be attributed to the preoccupation of practitioners in developing an epistemology of practice grounded in a model of technical

rationality, it can also be attributed to the reluctance amongst those involved in professional education to question the conceptual origins of health visiting strategies. This phenomenon has implications not only for the validity of the current assessment process, but also for the current crisis in confidence in health visiting practice.

#### A theoretical framework for assessing competence in practice

Therefore the evidence not only demonstrates the necessity to re-examine the validity and conceptual origins of strategies in health visiting but also questions the nature of professional knowledge. Although the data demonstrate a preoccupation with the desire to establish an appropriate scientific foundation to practice, the significance of the concept of professional artistry in making professional judgements in the individual practice setting is also clearly identified. Consequently competence in practice must be equally ascribed to the concept of professional artistry as well as to the knowledge and skills required in practice. However, I would argue that the current crisis in the profession can be attributed to attempts by practitioners to legitimise the professional status of health visiting by grounding practice in a model of technical rationality, as much as their failure in appreciating the essential role of professional artistry in practice. This has led some practitioners to not only negate the art of practice but also to adopt routinised and mechanistic approaches to practice thereby reinforcing a model of technical rationality. It is these phenomena which have contributed to the current conflicting paradigms of

practice and undoubtedly highlight the fundamental need for a theoretical framework for assessing competence in practice. A process which I would suggest would contribute to resolving the current dilemma in health visiting practice.

The theoretical framework for the assessment process in addition to drawing on a particular epistemology of practice, must reflect the conceptual origins of health visiting strategies. Therefore I would argue that the process must consider the grounding of practice and in order to address this issue I have attempted to construct a conceptual framework for practice from the principles of health visiting: the search for health needs, the stimulation of an awareness of health, influencing policies affecting health and the facilitation of health enhancing activities (CETHV 1977) and the paradigms of practice outlined in Chapter 1.

The outcome illustrated in Figure 10.1, identifies the client as the central focus in the health visiting strategy. This specifically relates to the need to overcome a fundamental criticism of practice: the tendency of professionals to define the health needs of clients using their own criteria instead of those of the client. Indeed by focussing on the client within the context of the community this does not restrict the framework to an individual or collective paradigm but is central to the formation of strategies in either setting.

The practitioner-client relationship, fundamental to effective practice outcomes, must incorporate the concept of partnership in order to determine strategies in practice appropriate to the clients'

A conceptual framework for health visiting practice

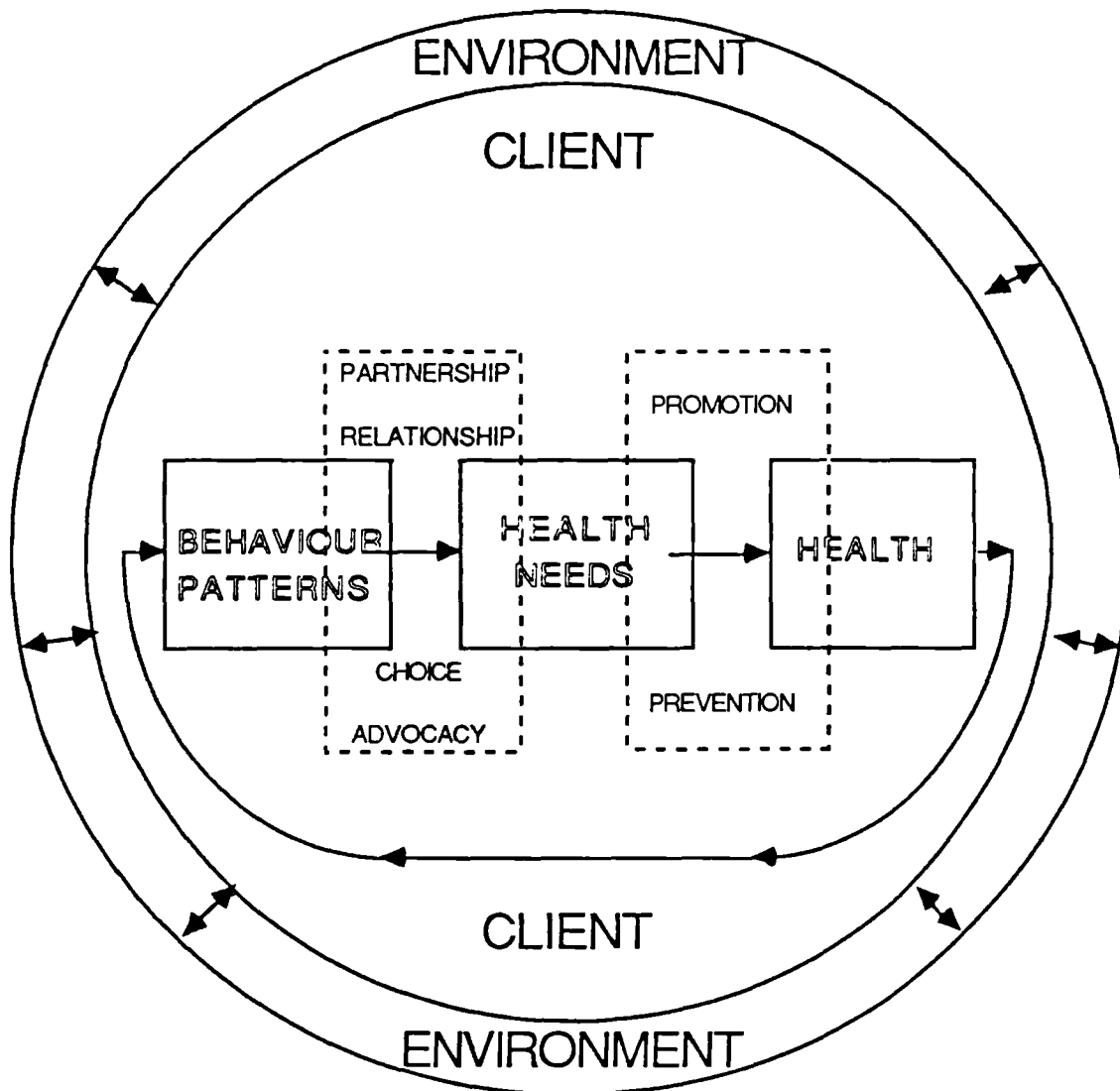


Figure 10.1.

perceptions of their health needs. Choice and advocacy, in addition to playing an essential role in this process, also indicate the political dimensions of practice in which I would suggest they assume an equally significant role. However the political dimensions of practice is specifically acknowledged in the concept of promotion and prevention. Promotion, interpreted within the context of the World Health Organisation's definition (WHO 1986) empowers and enables individuals to gain control over their own health, thereby facilitating them in taking responsibility for their own health status. These issues implicitly require practitioners to influence health policies at a local and national level, as well as participating in health education programmes. Prevention, at either a primary, secondary or tertiary level equally involves political action in addition to health education.

However it is the knowing-in-practice, by which practitioners make sense of the practice setting and thereby make professional judgements to inform and determine the strategies of promotion and prevention (facilitating change in the health behaviour and status of the client) which constitutes the concept of professional artistry. Implicit within this concept is the intuitive understanding of practitioners in making that professional judgement. In the context of my framework the concept of professional artistry is represented by the dotted line. This not only demonstrates the fundamental role of this concept in professional practice, but also indicates the need for the recognition of intuitive knowledge as a legitimate element of professional practice. This is why I have been led to argue that the grounding of practice strategies within this framework removes the emphasis from a task orientated scientific approach developed to

legitimise practice, to the beliefs and values underpinning practice, thereby facilitating practitioners in the development of an epistemology of practice generated by practice reality.

However the theoretical framework informing the assessment of competence in practice must also address the implications of a particular theory of the nature of professional practice. Undoubtedly the discussion has identified specific concerns about the use of a model of technical rationality in health visiting practice. Although partly attributed to the inherent circumstances of a professional group assigned to the category of a minor professional (thereby implicitly indicating ambiguous boundaries without a clearly defined context of practice making it impossible to develop a scientific body of knowledge), I would argue a more significant cause may be attributed to the moulding of practice situations to professional knowledge by either ignoring issues not corresponding to defined categories or attempting to force situations to conform to available techniques. Practitioners responding in this way not only contribute to the gap between theory and practice, but also ignore and negate a fundamental component of practice: the client-practitioner interaction and (of course as we have seen) the intuitive knowing-in-practice which informs and determines that interaction. Indeed this is why I have been led to argue that this particular approach to an epistemology of practice is inappropriate and an epistemology of practice which reflects the reality of practice and developments within professional practice, as in the case of reflection-in-action, should be adopted to inform the theoretical framework.

However a fundamental issue must be addressed when adopting this

particular theory of the nature of professional practice: the differentiation between reflecting-in-action and knowing in action. Schon (1987: 29) argues that this distinction may be subtle but identifies the major difference "as the on-the-spot experiment and further thinking that affects what we do" which is prompted by the rethinking of some aspects of knowing in action. Therefore reflection-in-action must, in addition to involving critical thinking about the knowing-in-action of practice, generate on the spot experimental actions. In order to develop this particular theory of the nature of professional practice two processes must occur: the practitioner must draw on previous practice experience to use as a framework on which to form hypotheses from similarities perceived in the practice situation and then test these hypotheses by experimental action in the practice setting. This process will also generate legitimate practice issues for research and therefore lessen the inconsistency between the foci of research and the reality of practice. However this approach in developing an epistemology of practice highlights the fundamental role of the practicum in facilitating these processes in not only student learning but also in the assessment of competence in practice.

Although it is difficult to identify the learning outcomes of a reflective practicum I would suggest these must be considered within the context of the theoretical framework of the assessment process. Schon (1987) describes a method of identifying the extent of the learning outcomes achieved by the student as two poles of an axis thereby representing a continuum along which the students' learning may be portrayed. Within this paradigm he identifies four specific elements and despite his acknowledgment that it is particularly difficult to specifically identify the outcome of student learning as

"the experience of the practicum can take root in the subsoil of the mind" (Schon 1987: 168), (therefore influencing the individual's future professional development), I would argue that this paradigm provides an appropriate foundation for assessing the extent of the learning outcomes in the health visiting practicum.

The first element reflects to the student's ability to articulate her understanding of practice issues in the context of health visiting; with one pole of the axis representing the learning outcome of a student who can only repeat the words she has heard in the practicum but is unable to relate them to experience or action. However, the other pole represents the student who has achieved an understanding of the processes to which the practice issues relate. The second element reflects the procedures the student experiences in the practicum; with one pole representing the learning outcome of a student who can only undertake discrete procedures, whereas the other end represents the student who can integrate and combine different procedures in the context of practice, with an understanding of the consequences or implications of those procedures. Within the third element one pole represents the student's ability to problem solve in one specific practice setting; whereas the other pole represents the student's ability to interpret that practice issue in a variety of ways, thereby providing a foundation for rethinking and experimenting in future practice. The final element reflects the student's ability to understand the interpretation of practice presented by the FWT. One pole represents the learning outcome of the student who perceives this approach as the only or indeed correct interpretation, whereas the other pole represents the student who perceives the interpretation as one view, to be critically analysed, juxtaposed and integrated with other views. This paradigm not only informs the



theoretical framework of the assessment process but also once more highlights the fundamental role of the student-FWT dialogue in the effectiveness of the practicum.

Therefore I would argue that the above discussion identifies four specific factors significant in determining the theoretical framework of the assessment process:

- the interpretation of professional practice,
- an epistemology of practice grounded in reflection-in-action,
- the learning outcomes of the practicum,
- the student-FWT dialogue.

Indeed I would suggest that each of these is equally significant to the process. The interpretation of professional practice identified in the conceptual framework presented earlier in the chapter highlights the inappropriateness of specifically identifying a particular set of knowledge and skills. However it also identifies the essential role played by the concept of professional artistry, in particular the intuitive understanding of the practitioner, in making professional judgements which determine the health visiting strategies realised in practice. In using this approach in the interpretation of professional practice it facilitates the assessment of the student's ability to understand the conceptual origins of these strategies. Although the particular theory of the nature of professional knowledge adopted for the framework is complex in the demands it makes on practitioners, particularly as it requires individuals to not merely reflect on their knowing-in-practice but reflect-in-action, it provides the opportunity of assessing the student's ability to manage the unique practice setting, in addition to the changing needs of professional practice.

Although the learning outcomes are significant in determining the student's ability to manage practice issues in the practicum (and therefore implicitly in practice), I would argue that the outcomes may also reflect the effectiveness of the practicum. The location of specific outcomes on the continuum may reflect the 'career' of the student's dialogue with the FWT as much as the student's ability in practice. Indeed the student-FWT dialogue, although fundamental in the framework of assessment, has been clearly identified as a major factor influencing the effectiveness of the practicum. This not only relates to the FWT's expertise in travelling the ladder of reflection and the student's enthusiasm and commitment to participating in the practicum, but also to the student-teacher relationship which is particularly relevant in an andragogic learning environment. Therefore I would argue that although the learning outcomes and the student-FWT dialogue are essential in determining the theoretical framework for assessing competence in practice, the earlier evidence which demonstrates the conflict in the interpretation of professional practice and the learning binds which develop in the practicum, highlight the continuing complexity of the assessment process in the current paradigm of health visiting education.

#### The implications for practice

The traditional interpretation of practice grounded in a model of technical rationality has led many practitioners, to perceive competence in practice merely within the context of a defined body of knowledge and specific skills. This therefore restricts the practitioner's understanding of competence in practice and implicitly the assessment process. Indeed I would argue that a serious consequence of attempts to legitimise professional practice by applying professional knowledge to instrumental problems of practice,

is the denial of the significance of the concept of professional artistry in the process of professional judgement. Indeed this process not only includes decision making but also implementing effective health visiting strategies in practice. Although the significance of the interpretation of professional practice within the conceptual context of professional artistry is highlighted throughout the data, this phenomenon in itself creates a further dilemma for health visiting education. The concept of professional artistry, particularly the intuitive knowing-in-practice which informs and determines effective strategies in practice, cannot be identified as a tangible component of the curriculum nor therefore included as an explicit element within the syllabus. An appreciation of the significance and role of professional artistry is dependent upon the interaction and dialogue between the student, FWT and client; and in particular reflects the FWT's ability to negotiate the ladder of reflection, both in relation to specific practice issues and role modelling.

However, if this interpretation of professional practice is adopted; an action I believe to be essential if an attempt is to be made to resolve the current crisis in health visiting, this process will raise further questions about the education and training of health visitor students, particularly in relation to the professional competencies stated in the Statutory Instrument (1983:873). Although wide ranging in interpretation, I would argue they remain clearly within the context of a skill base problem solving paradigm. The competencies therefore do not consider either problem setting or the wider processes involved in making professional judgements: strategies which are essential for competence in practice. It is this issue which demands the rethinking of the particular theories of

the nature of professional knowledge currently used to determine the interpretation of professional practice. Indeed I would argue that the development of an epistemology of practice grounded in reflection-in-action is an essential element in this process.

However the adoption of this particular theory of the nature of professional knowledge has significant implications for current practice. This approach demands that the practitioner is continually involved in analysing previous practice experience and formulating hypotheses which must be tested by experimental action; the results of which are used to inform and determine health visiting strategies. This process not only makes considerable demands on the cognitive ability of the practitioner but perhaps more significantly implicitly involves the practitioner in risk taking; a process which is not required when adopting a model of technical rationality. Nonetheless, it is these specific practice issues which are crucial in not only enabling the practitioner to adapt her practice to the individual practice setting, but also lessening the gap between the reality of practice and professional knowledge by facilitating the practitioner's involvement and participation in action research. However these issues once more highlight the significance of the effectiveness of the practicum (and therefore implicitly the FWT) in facilitating the student's achievement of the essential learning outcomes and in particular the ability to reflect-in-action.

Despite the earlier discussion highlighting the difficulty in identifying the learning outcomes achieved by the student during a reflective practicum, Schon (1987) argues that the location of the student's learning on the continua will be influenced not only by the student's ability to make sense of the practice world, but also

on the course of the student-coach dialogue. This he argues will be influenced by the abilities brought to that dialogue by the participants, particularly the ability of the coach to "adapt demonstration and description to the student's changing needs" (Schon 1987:169). Furthermore he goes on to argue that if a learning bind remains unresolved between the coach and student this is likely to adversely influence the position on the continua of the learning outcome achieved by the student. I would suggest this phenomenon has particular significance in health visiting education, as the findings demonstrate not only the limited interpretation of professional practice of many of the FWTs, but also the influence of role modelling on the student's perception of practice: factors which undoubtedly contribute to the learning binds experienced in the student-FWT interaction. Indeed it is this evidence which has led me to argue the significance of the FWT-student dialogue and in particular the demands this makes on the FWT throughout the practicum and the assessment process.

The demands created for the FWT in fostering an effective practicum are specifically identified in the final factor informing the theoretical framework of the assessment process. In addition this highlights once more the fundamental role of the FWT-student dialogue in the interpretation of professional practice. Indeed I would argue this finding is reflected not only in each of the factors informing the theoretical framework but also throughout my data. Undoubtedly it is the FWT-student dialogue which has significant implications for the implementation of effective health visiting strategies, particularly in relation to the interpretation of professional practice and the specific theory of the nature of professional knowledge which informs that interpretation. It is this issue

therefore which requires addressing, at both student and practitioner level, when considering the needs of those involved in the process of assessing competence in practice of student health visitors.

However within the context of addressing the needs of those involved in the assessment process there are two distinct issues which must be considered: the discrete needs of the specific groups of individuals involved in the assessment process and the implications of the thesis in relation to those groups. Therefore the interpretation of professional practice, the epistemology of practice which informs that interpretation and the implications for assessing competence in practice must be considered in relation to the individual needs of the students, practitioners and clients. Despite the similarities between the student and practitioner group, each will be considered separately when addressing their needs in relation to the student dialogue and the process of assessing competence in practice.

As previously identified the practitioners involved in the assessment process include FWTs and lecturers in health visiting. Despite their different roles and responsibilities in initiating and fostering a dialogue with the student, I would argue that the data clearly demonstrate the similar needs of both groups in the interpretation of professional practice and the implications for defining competence in practice. A major finding indicates the need for practitioners to make use of a conceptual framework for health visiting in their interpretation of professional practice. This would not only facilitate the identification of the underlying principles and beliefs of practice, thus enabling practitioners to adapt to the changing health needs of individuals, but also facilitate the development of a ladder of reflection from which practitioners could

analyse and debate specific practice issues thereby increasing the quality of the student-FWT dialogue. Similarly the findings clearly indicate the need for a theoretical framework for the assessment process. This would enable practitioners to move away from an interpretation of competence in practice which is limited to a definition of prescribed knowledge and skills and which contributes to the current crisis in health visiting practice. However I would suggest these issues generate further needs for the practitioner, in particular the ability to develop strategies to cope with the change and conflict which may be created by a dialogue with the student which approaches the ideal of reciprocal reflection-in-action in the practicum.

Although I have previously identified the students as a group with discrete needs in relation to the assessment process and the quality of the student-practitioner dialogue, I would suggest that the practitioners' needs identified above are reflected in the student group. Indeed the development of a conceptual framework for practice, the development of a theoretical framework for the assessment process and the ability to develop strategies to manage change and conflict are equally significant to the student. However these issues must be considered from the student's perspective, in particular the influence of the "andragogic" relationship which exists between the student and the practitioner (as described in Chapter 2). Issues such as the student's previous experience, both professional and education, her commitment to the practicum and her initial aptitude for participating in a process of reflection-in-action have implications for the quality of the student-practitioner dialogue. This in turn will influence the process of assessing her competence in practice.

The clients form the final group with needs which must be considered specifically in relation to the quality of the student-FWT dialogue. The findings demonstrate the fundamental role that clients play in student learning in the practicum; not only by providing a forum in which the student can rehearse her practice but also in observing the student-FWT interaction and indeed the potential for formal involvement in the assessment process. However I would suggest that this participation places the client in a potentially vulnerable position, particularly if the student is experiencing difficulties in developing an interpretation of professional practice which acknowledges the essential role of an appreciation of the concept of professional artistry. I would therefore argue that the clients, in addition to requiring an understanding of the processes involved in the student-FWT dialogue and the factors which may influence that debate, also require some understanding of the conceptual framework for health visiting. This is particularly pertinent if they are to participate in the development of an epistemology of practice grounded in reflection-in-action. Indeed I would argue these issues have major implications for the briefing required by clients if they are to meet the learning expectations of the practicum and the FWT must play the major role in facilitating this process.

The above discussion highlights some of the implications for practice of my thesis, in particular those relating to the current crisis in health visiting practice. However I would argue that the most significant implication is the demand for a fundamental change in health visiting education and the methods used to assess competence in practice. Since my research set out to investigate the nature of professional knowledge as perceived by those involved in health



visiting education, and to explore the relationship between the process used to assess competence in practice and the interpretation of professional practice, it would be beyond the scope of this thesis to draw up a detailed plan or proposal for changes in health visiting education. However the principles which emerged from my thesis prompt the following changes in the education and assessment of health visitor students.

#### Towards a method for practical implementation

- (i) The first major proposal developed from the thesis concerns the role of the concept of professional artistry in the interpretation of professional practice in health visiting education. As previously described, although fundamental to competence in practice, this concept cannot be considered as a discrete component of the syllabus. Therefore exploring this element of professional practice is particularly dependent on the FWT's ability to not only reflect on practice and explore and analyse the findings of this process in the dialogue with the student, but also display the concept in the role model presented to the student. However in order to effectively facilitate an appreciation of this concept in the education and training of student health visitors I would suggest two fundamental measures are required: research to explore and analyse how practitioners exhibit and interpret the intuitive knowing-in-practice which informs the decision making in the phenomenon of professional judgement and major changes in the education and training of FWTs. The latter would not only necessitate the development of a conceptual framework for fieldwork teaching but also require major changes in the structure and content of the Fieldwork Teachers Course. This in turn has implications for the approvals procedure carried out by the English National Board.

(ii) The second major proposal to emerge concerning health visiting education is the introduction of an epistemology of practice grounded in a model of reflection-in-action. This will not only require practitioners to participate in action research using protocols of actual performance to construct and test models of knowing-in-practice but also to facilitate this process in the learning of student health visitors. Once again this will make demands on the cognitive ability of the FWT particularly in relation to the development of the student-FWT dialogue and the practice exhibited in the role model offered to the student. However this particular interpretation of the nature of professional knowledge, demanding practitioners to constantly reflect-in-practice, introduces a third proposal for change: an analysis of practice in the context of peer audit review.

(iii) Peer audit review provides the opportunity for practitioners to "meet together to generate agreed standards of good practice and then audit their own practice using some form of self or peer assessment" (Heron 1981:16) This process therefore provides a forum for not only undertaking a critical analysis of the interpretation of professional practice but also for self and peer appraisal. This I would suggest is essential in maintaining and developing standards of professional practice and in contributing to resolving the current crisis confidence in professional practice.

Indeed I would argue that these proposals once more highlight the fundamental need for a conceptual framework for health visiting practice from which professional judgement can evolve to inform and determine effective health visiting strategies. However I would

argue that this belief has major implications for the competences defined in the Statutory Instrument (1983:873) for the education and training of health visitor student. Although wide ranging in their interpretation they are currently limited to a problem solving approach to practice. Nonetheless it is the need for the student to rehearse the professional judgements which determine competence in practice that indicates another significant proposal to emerge from the thesis: the fundamental demand for an effective practicum.

- (iv) The significance of the effect of the practicum on the outcome of student learning has been highlighted throughout the data. The need for the FWTs to not only provide the students with the opportunity to rehearse their practice in a setting, which although protected represents the reality of practice, but also to analyse, debate, criticise and evaluate the student's practice has implications for both the education and training of FWTs and their role as a practitioner. I would argue this once more indicates the need for change in both the structure and content of the course offered to FWTs. This particularly relates to providing the FWT with the opportunity of extending and developing the ability to reflect-in-practice, as well as the ability to facilitate this process in the student. However, this proposal also has implications for the organisation of the FWTs' time in the health authority. It demands an understanding and acknowledgement by managers of the time and skills required by the FWT in participating in an effective practicum. This may include not only the reduction of the FWT's caseload but also promoting different methods of working such as facilitating group work and networking.

(v) The fifth and final proposal developed from the thesis directly relates to the role of client in the practicum. The role of clients not only in acknowledging the significance of the concept of professional artistry, but also of the attitudes and personal attributes of the students' in influencing their ability in demonstrating an appreciation of the concept of professional artistry, has been clearly identified. Indeed I would suggest this finding provides a valuable source of data in the process of assessing competence in practice. Therefore although clients already participate in the practicum, their role must be more clearly defined, particularly in relation to the structure of their interaction with the FWT and student and the student-FWT dialogue. However the most significant issue in this proposal is the formal participation of clients as an essential component of the assessment process; indeed a process which I believe may contribute to resolving the crisis in health visiting practice.

It is significant that although this research pertains to the interpretation of professional practice in health visiting and the relationship of that interpretation to the assessment of competence in practice, the proposals developed from the thesis are equally pertinent to nurse education. The introduction of Project 2000, and the challenge of health for all by the year 2000, demand the 'knowledgeable doer' who can adapt and build on practice to meet the changing needs of patients and their families. In order to meet this demand practitioners in nurse education will also need to address issues such as the concept of professional artistry, the use of intuitive knowing-in-practice, the factors influencing the effectiveness of the practicum, the role model presented in the practicum and in particular the role of consumer participation in

nurse education. I would therefore argue that the thesis generally has significant implications for nurse education and as such provides a major source for further research by practitioners.

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# Council for the Education and Training of Health Visitors

## CONFIDENTIAL

### Form of Assessment for the Period of Supervised Practice

#### Part II Examination

Name of Student .....

Training Institution .....

Dates of Practice From ..... To .....

Name of Area Health Authority or Board .....

Name of Health District .....

#### 1. Description of the setting where the student was working

(Refer to explanation of terms used at page 6.)

##### a) Geographical Area or Practice Link

--

If Practice Link:

Maison  
Alignment  
Attachment


##### b) Based in:

Surgery  
Health Centre  
Clinic


Any other? (Please indicate) .....

##### c) Caseload allocated to student during supervised practice

--

##### d) Caseloads carried by Health Visitors in the group within which the student is working (See a) above)

--

is expected that all students will have the following experience during revised practice, but this should not be regarded as exclusive of other acts of health visiting.

Assessment of the ability of the student

Tick in appropriate box

X = Extremely good ability

Y = Poor ability

X	TENDING to X	TENDING to Y	Y
APPLIES			APPLIES

Organisation of Work

1. Planning of Work: a) Short term  
b) Long term  
c) Overall
2. Assessment of Priorities
3. Record Keeping
4. Report Writing
5. Ability to cope with crisis situations


Any additional comments .....

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.....

Home Visiting Activities

1. Establishment of relationship with individuals
2. Ability to show an attitude of acceptance to clients of all types
3. Health Visiting assessment of family situations
4. Identification of needs
- Planning of Care: 5. Short term  
6. Long term
- Implementation of Plan: 7. Short term  
8. Long term


Any additional comments .....

.....

.....

.....

### C. Clinic Management

1. Organisation and management of a clinic
2. Relationship with colleagues in the clinic team
3. Establishment of relationships with the clinic personnel
4. Ability to give relevant advice in terms understandable by the client
5. Organisation of subsequent action


Any additional comments .....

.....

.....

.....

### D. Group Teaching

1. Awareness of Health Education needs in the area
2. Ability to draw on available resources
3. Ability to plan group teaching
4. Ability to implement group teaching plans
5. Self evaluation in group teaching


Any additional comments .....

.....

.....

.....

### E. Contact with other Agencies

1. Knowledge of statutory and voluntary agencies in the area
2. Selection of the appropriate agency
3. Understanding of the need for discretion in the use of confidential material
4. Establishment of relationship with workers of different agencies
5. Awareness of case conference/case discussion techniques
6. Demonstrate the ability to successfully introduce family and agency


Any additional comments .....

.....

.....

.....

General

Student's ability to work with,  
and relate to:

- a) Colleagues of own discipline
- b) Colleagues of other disciplines
- c) Nursing management

Professional approach to work and clients

Interest in general developments in the  
profession


Any additional comments .....

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Please comment on particular strengths or weaknesses of this student

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N.B. This form should not be completed until at least seven weeks of supervised practice have been undertaken.

4. R E C O M M E N D A T I O N

In your opinion, has this student satisfactorily completed the period of supervised practice?

YES	NO
-----	----

(Please TICK the appropriate box)

NOTE: If "NO", please be certain that the reasons for this decision are made quite clear in your report. Space has been left at Question 3 for such comments.

Signature of Assessor .....  
Name in BLOCK CAPITALS .....  
Designation .....  
Date of Completion of Form .....

5. T O B E C O M P L E T E D B Y T H E S T U D E N T

I have seen this completed form and discussed its contents and recommendations with my assessor.

Signature of Health Visitor Student .....  
Date .....

APPENDIX B



**United Kingdom Central Council  
for Nursing, Midwifery and Health Visiting**  
23 Portland Place, London W1N 3AF

**SSION TO THE PROFESSIONAL REGISTER DECLARATION OF CHARACTER**

I \_\_\_\_\_ of  
(insert full name)

\_\_\_\_\_ of  
(insert school or college)

of education/  
Institution

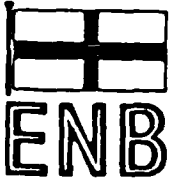
state that on the basis of his/her character and conduct during a course of professional education and training completed on \_\_\_\_\_ I consider

PIN/Index Number \_\_\_\_\_

to be a fit and proper person to be admitted to the professional register for nurses, midwives and health visitors.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Post held \_\_\_\_\_



## ENGLISH NATIONAL BOARD

## C O N F I D E N T I A L

FORM OF ASSESSMENT FOR THE PERIOD OF SUPERVISED PRACTICEHEALTH VISITOR COURSE: FINAL ASSESSMENT

This form should be used as a guide throughout the Period of Supervised Practice but not completed before the ninth week of supervised practice.

The experience provided during the placement should enable contact to be made with all age groups, and a range of social classes and cultures.

Name of Student .....

Training Institution .....

Dates of Practice .....

Name of Health Authority .....

1. Type of supervised practice base

a) Health Authority Premises

Health Centre .....

Other (Please state).....

b) General Practice Premises .....

c) Other Premises (Please indicate type) .....

The following objectives should be commented on in order to ensure that the student reaches the required level of health visiting competencies (see Statutory Instrument 83/873 Nurses, Midwives and Health Visitor approval order Part IV Section 24). (See Appendix 2)

#### **7. Health Visiting Practice: Services for the community**

At the end of Supervised Practice the student should be able to:

- i) analyse health visiting and related records in the assigned population;
- ii) analyse health statistics and socio-economic factors relating to the assigned population;
- iii) identify and review health care needs in the population assigned;
- iv) ascertain and interpret local policies affecting health;
- v) determine health visiting priorities within the assigned population;
- vi) carry out surveillance and screening programmes;
- vii) contribute to work of committees, working groups and case conferences as appropriate;
- viii) formulate and implement formal health education programmes;
- xi) identify where self help groups might be appropriate.

Please comment on the progress made by the student during Supervised Practice and the level of competence achieved.

## **9. Health Visiting Practice: Services for school children**

At the end of Supervised Practice the student should be able to:

- i) plan and participate in health surveillance programmes for individual children and groups;
- ii) participate in school health activities including assessments and form a link between home, school and other workers;
- iii) formulate and implement health education programmes in school;
- iv) initiate and maintain contact with School Nurses;
- v) understand the Health Authority's policy for health surveillance and screening programmes in schools;
- vi) be familiar with the policies relating to children with special needs and available resources.

Please comment on the progress made by the student during Supervised Practice and the level of competence achieved.

# **11. Health Visiting Practice: Teamwork**

At the end of Supervised Practice the student should be able to:

- i) contribute to teamwork in relation to primary health care;
- ii) establish and maintain professional relationships at all levels;
- iii) manage work load using skills and resources of others where available and appropriate.

Please comment on the progress made by the student during Supervised Practice and the level of competence achieved.

**13. RECOMMENDATION**

In your opinion, has this student satisfactorily completed the Period of Supervised Practice and demonstrated the competencies required for registration as a Health Visitor?

(Please tick the appropriate box)

YES      NO

- NOTE:
1. If "NO" please indicate the section/s within the report which lead/s you to make this recommendation. Please indicate if any remedial action was recommended or taken during the Period of Supervised Practice.
  2. Is there any further information which, with the agreement of the student, you would wish to bring to the attention of the examiners.

Signature of Assessor .....

Name in BLOCK CAPITALS .....

Designation .....

Date of Completion of Form .....

**14. TO BE COMPLETED BY THE STUDENT**

I have seen this completed form and discussed its contents and recommendations with my assessor. Please comment, briefly, on any matter you wish to draw to the attention of the examiners.

Signature of Health Visitor Student .....

Date .....

## APPENDIX 1

### Definition of Caseload and Workload

1. A health visiting caseload is the population for which the health visitor has a designated responsibility. It could be based on a general medical practitioner caseload, a geographically defined catchment area and/or specific school or other institution populations.

Although not necessarily involved with all of the population on a frequent contact basis, the responsibility for the whole population as defined by the employing authority is ongoing. This approach is comparable with general medical practitioner caseloads for which there is a continual responsibility but not all clients are seen on a regular basis. This concept of caseload differs from that of social workers where the caseload is usually reckoned to be the number of cases for whom they have a specific responsibility at a particular point in time.

2. The workload encompasses the whole range of activities for which the health visitor has professional responsibility. This includes work with all those individuals, families and groups with whom the health visitor is in professional contact, the identification of other health needs within the caseload, and planning and implementing appropriately innovative responses. It also includes participating in activities related to developments within health and associated services.



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STATUTORY INSTRUMENTS

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1983 No. 873

NURSES, MIDWIVES AND HEALTH VISITORS

The Nurses, Midwives and Health Visitors Rules Approval Order  
1983

PART IV

Health Visitor Training Rules

The kind and standard of training leading to qualification as a  
health visitor

- 24 - (1) The kind and standard of training leading to qualification enabling an application to be made for admission to Part 11 of the register under this rule shall enable the student to acquire the necessary knowledge, skills and attitudes for her personal professional development and for the student to develop the competencies required to practice health visiting which will require:-
- (a) co-ordination of skills in health assessment, identification of need, planning, implementation and evaluation of health education and care;
  - (b) co-operation with persons engaged in a wide range of primary health care and other colleagues;
  - (c) encouragement of community participation and use of voluntary workers in health enhancing activities.

APPENDIX D

To Sheila F. Twinn,  
Senior Lecturer,  
Faculty of Business and Social Studies,  
Croydon College,  
Fairfield, CROYDON, CR9 1DX.

.....

1. How adequate do you feel present methods are for measuring students' practical competence (particularly when considering the difficulties in defining competent clinical practice)?

2. To what extent do you think fieldwork teachers feel sufficiently competent and confident when completing the student's assessment?

3. Do you have any plans to revise or change your assessment procedures in the near future?

4. Any other particular area of concern in the assessment of fieldwork practice.

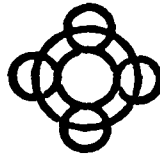
Date: .....

Signed: .....

College:

APPENDIX D

Business and Social Studies  
cult. David M. Boll, BA (Oxon)



Croydon College  
Fairfield · Croydon CR9 1DX  
☎ 01-688 9271 6

SFT/ELM.

2nd April, 1984.

Dear

I am working in health visitor education and am particularly interested in the assessment of health visitor students' competence in fieldwork practice.

I am currently undertaking an exploratory study of the assessment procedures used for student health visitors during their fieldwork practice. (This is part of my work towards a higher degree at London University Institute of Education and is being undertaken with the knowledge and approval of the Professional Officer at the English National Board, Miss M. Thwaites). I feel it is very important to start by reviewing the methods currently employed by Colleges.

- (a) I would be extremely grateful if you would send me a copy of the assessment form or guidelines that are being used by the fieldwork teachers and students in your College. It would also be helpful to know if you do not use a formal method of assessment.
- (b) I should also be grateful to have comments about your own experiences and opinion of the assessment of fieldwork practice in the form of answers to the questions on the attached sheet.

A stamped, addressed envelope is enclosed.

Thank you very much for your help.

Yours sincerely,

Sheila F. Twinn (Ms.)  
SENIOR LECTURER

Encs.

Education and Social Studies  
Faculty - C. P. Hughes Blect C. E. g. Mithun



Croydon College

1000 Croydon Road  
Croydon, Surrey CR9 3AT

SFT/ELM.

14th December, 1984.

Dear

During my work in health visitor education, I have become particularly interested in the procedures used to assess the student's competence in fieldwork practice. Having recently registered for a higher degree at the Institute of Education, my research topic is an exploratory study to evaluate the current assessment procedures used for fieldwork practice.

As you are aware, the new examination regulations place a much greater emphasis on the fieldwork teacher's opinion of the student's competence to practise as a qualified Health Visitor. I am, therefore, very interested in the fieldwork teacher's opinion of the completion of the assessment and would like to involve them in evaluating our current procedures.

I would be very grateful if you would consider it appropriate for your fieldwork teachers to participate in this project. At the last Study Day we did discuss the possibility of undertaking this study and they seemed happy to be involved.

Thank you very much for your help.

Yours sincerely,

Sheila F. Twinn (Ms.)  
SENIOR LECTURER

APPENDIX F

CROYDON COLLEGE

FACULTY OF BUSINESS AND SOCIAL STUDIES

CONFIDENTIAL QUESTIONNAIRE FOR FIELDWORK TEACHERS

Please tick where appropriate.

PART I - Professional Details

1. In which year did you undertake the Fieldwork Teacher (FWT) Course?

2. Did you have to undertake Part II to complete the FWT Course?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

If yes, please state the year.

3. Did you request to attend the FWT Course?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

If no, who did request that you applied for the course?

4. How would you describe the coverage of the topic of student assessment during the theoretical section of your course?

None at all  
Some but inadequate  
Sufficient  
Too much

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Are there any other comments you would like to make?

5. Do you have a student in the present academic year?

	YES
	NO

6. How long have you been training student health visitors as a qualified FWT?

Completing Part II

1 - 3 years

4 - 7 years

8 - 12 years

13 years or more


If completing Part II, please proceed to question 10.

7. Do you regularly train student health visitors?

	YES
	NO

If no, when did you last have a student?

1 year ago

2 - 3 years ago

4 - 5 years ago


8. Do you feel that a Fieldwork Teacher should have a rest year from training student health visitors?

	YES
	NO

Please comment on your answer.

9. Do you have a student from the same college each year?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

10. If possible, do you feel it is important to have a student from the college where you completed your FWT course?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

11. Do you feel that your case load gives adequate representation of health visiting skills?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

12. Please indicate the size of your case load, using one of the categories below.

Population  
Families  
Children under 5  
Other

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

13. Are you based in premises with other members of the Primary Health Care Team?

	YES
	NO

If yes, please specify

HV	
DN	
GP	
SN	
CPN	
Other (please specify)	

14. Is your working situation

GP attachment	
Geographical	
Other (please specify)	

15. Have you implemented the health visiting process in your particular working situation?

	YES
	NO

Do you feel the 'process' is a useful teaching tool?

	YES
	NO

Please comment on your answer.



PART II - The Assessment Procedure

16. Do you feel it is the responsibility of the FWT to assess the practical competence of the student health visitor?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

17. Do you feel adequately trained to undertake the assessment of student health visitor's fieldwork practice?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

18. Do you find it particularly stressful to complete the formal assessment procedure with your student?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

19. Which health visiting skills do you consider to be the most important for assessing the student's practical competence?

20. What other criteria would you use to assess the practical competence of student health visitors?

21. Do you consider the student's personality affects his/her practical competence as a health visitor?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Which particular traits would you consider important?

22. Do you feel that your assessment is influenced by the student's personality?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please illustrate your answer with an example.

23. Do you consider it difficult being both the teacher and the assessor of the student?

	YES
	NO

Please comment on your answer.

24. Are you able to meet regularly with your student to make an informal assessment of his/her practical competence?

	YES
	NO

Do you feel this is a useful process?

	YES
	NO

Please comment on your answer.

25. Do you feel it would be useful for the student to undertake a formal self assessment of his/her practical competence?

	YES
	NO

Please comment on your answer.

26. Do you consider comments from colleagues when assessing the practical competence of your student?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please illustrate your answer with an example.

27. Do you consider comments from clients when assessing the practical competence of your student?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

28. Have you ever failed a student due to the incompetence of his/her fieldwork practice?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

29. Do you feel that the college tutorial staff should be involved with the assessment of a student's practical competence?

	YES
	NO

Please comment on your answer.

30. Please indicate which of the methods below you would rather use to submit the student's formal assessment.

Written report  
Structured form


Please give reasons for your choice.

31. Which particular aspects do you find most difficult when undertaking a formal assessment of your students' practical competence?

32. Would you consider it useful to have your  
assessment of the students' practical performance  
validated by another FWT?

☐ YES  
☐  
☐ NO

Please comment on your answer.

33. What changes would you like to make which would  
improve the methods of assessing a student's practical  
competence?

THANK YOU VERY MUCH FOR YOUR HELP.

SHEILA TWINN



Croydon College

1000 High Street, Croydon, Surrey, CR9 1AB

Telephone: 01889 551111

10th December 1984

Dear

During my work in health visitor education, I have become particularly interested in the procedures used to assess the students' competence in fieldwork practice. Having recently registered for a higher degree at the Institute of Education, my research topic is an exploratory study to evaluate the current assessment procedures used for fieldwork practice.

As you may be aware, the new examination regulations place a much greater emphasis on the fieldwork teachers opinion of the students competence to practice as a qualified health visitor. I am therefore very interested in your opinion of our present assessment procedure.

I would be extremely grateful if you would complete the enclosed confidential questionnaire, and return it to me by January 7th 1985. I must apologise for the length of the questionnaire but feel this is necessary to do justice to the importance of the topic and your opinions. I enclose a stamped, addressed envelope.

May we also take this opportunity of thanking you for your help with the students and wish you a very happy Christmas.

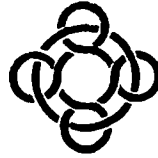
Thank you very much for your help.

With best wishes  
Yours sincerely

Sheila F Twinn (Ms)  
Senior Lecturer in  
HealthVisiting

APPENDIX H

Faculty of Business and Social Studies  
Faculty C P Hughes BTECH CEng MIPRODE



Croydon College  
Fairfield · Croydon CR9 1DX  
01-688 9271-6

Dear

I am writing to ask your help once again with my study into the assessment of student health visitors' fieldwork practice. The questionnaire which you very kindly completed raised more questions about our assessment procedures and there are now further ideas which I would like to explore in more depth with a random sample of Fieldwork Teachers.

As you have been selected in the sampling I wondered if you would agree to answering some questions in confidence in an interview which would last approximately thirty minutes. It would be very helpful for me to tape the interview. I would be very grateful if you would agree to participate. The interview would obviously take place at a time and location that was convenient to you.

I do hope you feel able to participate and I look forward to hearing from you. I would be grateful if you could return the slip as soon as possible.

Thank you for your help.

Yours sincerely

Sheila F Twinn (Ms)  
Senior Lecturer in Health Visiting

---

To: Sheila F Twinn  
Senior Lecturer in Health Visiting  
Croydon College, Faculty of Business & Social Studies  
Fairfield CROYDON CR9 1DX

I am willing/unwilling to participate in the interview. I  
can be contacted at either (home phone no.)

or (work phone no.).

Signed.....

Name.....



APPENDIX I  
CROYDON COLLEGE

FACULTY OF BUSINESS AND SOCIAL STUDIES

INTERMEDIATE ASSESSMENT OF STUDENT HEALTH VISITORS' PRACTICAL WORK

NAME OF STUDENT

NAME OF FIELDWORK TEACHER

.....

.....

Please tick the appropriate boxes which are ranked 1 - 5 (excellent to very poor) and include in the space provided any further comments you may wish to make.

HEALTH VISITING SKILLS

EXCELLENT  
1 2 3 4 5  
VERY POOR

Observation

Observation of client interaction

--	--	--	--	--

Observation of clinical details

--	--	--	--	--

Comments:

Communication

Demonstrates listening ability

--	--	--	--	--

Demonstrates fluent verbal communication

--	--	--	--	--

Demonstrates interpretation of non-verbal communication

--	--	--	--	--

Demonstrates ability for concise written communication

--	--	--	--	--

Demonstrates ability to use other agencies appropriately

--	--	--	--	--

Comments:

Assessment

Ability to assess client's needs

--	--	--	--	--

Ability to assess the health visiting needs of a community

--	--	--	--	--

Comments

4. Management

1 2 3 4 5

Ability to organise client priorities

--	--	--	--	--

Ability to organise Child Health Clinic

--	--	--	--	--

Ability to organise clients' records

--	--	--	--	--

Comments:

5. Advising

Ability to ask appropriate questions for interviewing clients

--	--	--	--	--

Ability to interpret clients' needs during an interview

--	--	--	--	--

Ability to offer appropriate advice

--	--	--	--	--

Comments:

6. Teaching

Ability to undertake appropriate one-to-one teaching

--	--	--	--	--

Ability to undertake group education

--	--	--	--	--

Not applicable

--

Comments:

7. Evaluation

Ability to evaluate performance with clients

--	--	--	--	--

Ability to evaluate effectiveness of advice

--	--	--	--	--

Ability to evaluate non verbal interaction during a client interview

--	--	--	--	--

Comments:

PERSONAL QUALITIES

1 2 3 4 5

1. Perception

Ability to perceive clients' needs

--	--	--	--	--

Ability to perceive colleagues' needs

--	--	--	--	--

Comments:

2. Sensitivity

Ability to adapt to different cultural ideas

--	--	--	--	--

Ability to understand different social values

--	--	--	--	--

Ability to interpret clients' feelings

--	--	--	--	--

Comments:

3. Self Awareness

Ability to evaluate critically his/her work with clients

--	--	--	--	--

Ability to evaluate critically own interpersonal skills

--	--	--	--	--

Comments:

4. Professionalism

Ability to demonstrate a professional attitude to work

--	--	--	--	--

Comments:

Please comment on interaction with clients.

. Please comment on interaction with professional colleagues.

any further comments on student's performance:

Comments by student:

SIGNATURE OF STUDENT .....

SIGNATURE OF FIELDWORK TEACHER .....

DATE .....

APPENDIX J

CROYDON COLLEGE

FACULTY OF BUSINESS AND SOCIAL STUDIES

CONFIDENTIAL QUESTIONNAIRE FOR STUDENT HEALTH VISITORS

Please tick where appropriate.

PART I - Professional Details

1. In which year did you qualify as an SRN?

--

2. Please indicate other professional qualifications.

DN

SCM

Obstetric

RMN

RSCN

FP Cert

Non medical and other (please specify)


3. Please indicate your academic qualifications.

CSE

'O' Level

'A' Level

Degree

Other (please specify)


No. of  
Passes

"  
"

4. What was your occupation immediately prior to starting the health visitor course?

PART II - Your Fieldwork

5. Have you been allocated a caseload by your FWT?


YES

NO

If yes, proceed to question 6.

If no, proceed to question 10.

6. How many households does this include?

7. Please indicate the different types of client groups.

Antenatal women	<input type="checkbox"/>
Antenatal men	<input type="checkbox"/>
Children 0-12 months	<input type="checkbox"/>
Children 13 mths-5 yrs	<input type="checkbox"/>
Children 6-16 years	<input type="checkbox"/>
Children with a disability	<input type="checkbox"/>
Single parent family	<input type="checkbox"/>
Adults with a disability	<input type="checkbox"/>
Ethnic minority	<input type="checkbox"/>
Community groups	<input type="checkbox"/>
Mentally ill	<input type="checkbox"/>
Elderly	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

8. To what extent is this an appropriate selection of families for you as a student?

9. To what extent does this selection compare to those allocated to your peer group?

10. During your fieldwork practice have you had the opportunity of working with other members of the Primary Health Care Team?

	YES
	NO

If yes, please state disciplines.

11. With which other professional groups have you come into contact during your fieldwork practice?

12. To what extent has the theory taught in College been applicable to your fieldwork practice?

13. Would you like more fieldwork experience?

	YES
	NO

Please comment on your answer.

14. Is there any area of fieldwork practice which you have found particularly difficult?

	YES
	NO

Please comment on your answer.

### PART III - Your Assessment

5. Do you feel that you have enough regular discussions with your FWT about your level of practical competence?

	YES
	NO

If yes, do you find this a useful exercise?

If no, would you find this a helpful exercise?

6. Did you find the formal assessment procedure stressful?

	YES
	NO

Please comment on your answer.



17. To what extent was the formal assessment procedure a useful experience for you?

18. What do you consider to be the purpose of a formal assessment of your fieldwork practice?

19. Do you feel that this formal procedure provides a true assessment of your health visiting skills?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Please comment on your answer.

20.. To what extent would you find it useful to undertake a formal self-assessment of your health visiting skills?

21. Are you prepared to make written comments, using the appropriate space on the form, about your FWT's assessment of your level of practical competence?

	YES
	NO

Please comment on your answer.

22. What criteria do you feel should be used to assess your practical professional competence?

23. Does your FWT's role as an assessor as well as a teacher affect your relationship?

	YES
	NO

Please comment on your answer.

24. Do you feel that the personality of your FWT may affect his/her assessment of your practical competence?

	YES
	NO

Please comment on your answer.

25. Do you feel it would be fairer if another FWT also assessed your practical competence?

	YES
	NO

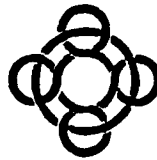
Please comment on your answer.

26. What changes would you like to make to improve the methods of assessing a student's fieldwork practice?

THANK YOU FOR YOUR HELP.

SHEILA TWINN

ty of Business and Social Studies  
of Faculty: C P Hughes BTech CEng MIProdE



Croydon College  
Fairfield · Croydon CR9 1DX  
☎ 01-688 9271-6

10th December 1984

Dear

' Since starting work in health visitor education, I have become particularly interested in the procedures we use to assess your level of fieldwork practice. I have therefore chosen this topic for my research for a higher degree at London University and have started an exploratory study to evaluate the current assessment procedures used for fieldwork practice.

Obviously your opinion of the procedures we presently use is very important and I would be extremely grateful if you would complete the enclosed confidential questionnaire and return it to me by January 7th 1985. I am sorry about the length of the questionnaire but feel this is necessary to do justice to the importance of the topic and your opinions. I enclose a stamped, addressed, envelope.

Thank you very much for your help.

Yours sincerely

Sheila F Twinn  
Senior Lecturer in  
Health Visiting

Enc

## APPENDIX L

### QUESTIONS FOR SEMISTRUCTURED CLIENT INTERVIEW

1. How long have you known your health visitor?
2. What particular things do you feel are helpful about your health visitor?
3. Are you happy with the health visiting service that is provided for you?
4. Are there any things which you do not find very helpful?
5. Have you been involved with a student health visitor before?
6. Did your health visitor explain that it was a student who would be visiting you?
7. Have you enjoyed having a student visit you?  
If YES/NO are you able to say why?
8. Do you find the student helpful?
9. Is there anything you particularly like about the way she works which is different from how your health visitor works?
10. Are there any other ways in which having a student made to your contact with your health visitor?
11. Is there anything you find particularly difficult about the student/or having a student?

2.

12. Would you like to be more involved in the students' training by being asked to give your opinion of their suitability as a health visitor?

If YES - have you any ideas how you might help your health visitor do this?

If NO - are you able to say why?

13. Do you feel its too difficult for you to give your opinion of the students' health visiting ability?

If YES/NO are you able to say why?

14. Are you able to say what you would do if you were unhappy with the student visiting you?

15. How do you feel about us using families to help train student health visitors?

16. Can you think of any other ways we could improve the training of health visitor students?

17. Would you feel differently about your views, do you think, if I was asking these questions:

At Home

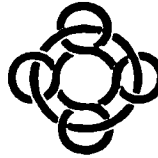
In the Clinic

18. Do you feel that you would be able to share your views more if other women were present (such as a mother and toddler group or post natal group)?

THANK YOU VERY MUCH FOR YOUR HELP.

APPENDIX M

ty of Business and Social Studies  
of Faculty: C P Hughes BTech CEng MIProdE



**Croydon College**  
Fairfield · Croydon CR9 1DX  
☎ 01-688 9271-6

Dear

You may remember I wrote to you last year about my research project considering the assessment of the practical competence of student health visitors. I found the information extremely useful and now that I am in the process of writing up the original work, it has become obvious that I must also include the Health Visiting Studies which the students submitted for Part II of the examination. I am once again requesting your help.

I would be grateful if you would be prepared to send me a copy of the guidelines which you provide for the students and fieldwork teachers, and would be extremely interested in your comments on the enclosed questions.

I enclose a stamped addressed envelope.

Thank you for your help.

Yours sincerely

Sheila F Twinn (Ms)  
Senior Lecturer in Health Visiting

Enc

TO Sheila Twinn  
Senior Lecturer in Health Visiting  
Croydon College  
Faculty of Business and Social Studies  
Fairfield  
Croydon CR9 1DX

- 1 To what extent do you feel the studies are a useful method of  
, assessing the students' health visiting skills?
- 2 To what extent do you offer tutorial help during the preparation  
of the studies?
- 3 Do you experience any difficulties with the use of your guide-  
lines for the health visiting studies?



4 In your opinion to what extent are the Fieldwork Teachers involved in the preparation of the studies?

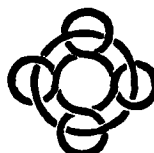
5 Do you use your guidelines as a tool to assess the health visiting studies?

6 Do you have any concerns about using the health visiting studies as an assessment procedure?

7 To what extent do you feel the studies are stressful for the students?

COLLEGE.....

DATE.....



FACULTY OF INFORMATION, TRAINING & SOCIAL SCIENCES

Dear

Your name has very kindly been given to me by  
as someone who might be interested in allowing me to carry out a short  
interview. The purpose of the interview is to find out how you might feel  
about being more involved in the assessment of the practical work of  
Student Health Visitors.

All the research has shown the very important part played by parents in  
recognising the skills of a good Health Visitor and we would like to  
introduce this area into our training of Student Health Visitors.  
Obviously, the interview would be held at a time and place convenient  
for you, this may be either at your home or in the Clinic. The questions  
would be really to get your feelings about what you think makes a good  
Health Visitor and how we might involve parents more in the training of  
Health Visitors. Obviously, all your comments would be treated in total  
confidence.

I would be very grateful if you do feel able to help me in my Study and  
I look forward to hearing from you. I have enclosed a tear-off slip and  
a stamped, addressed envelope for your use.

Yours sincerely

Sheila F Twinn (Ms)  
Senior Lecturer in Health Visiting

-----  
I am willing/unwilling to be interviewed for the Study. My phone no. is  
for you to call to arrange a convenient date and time.

Name .....

APPENDIX P

Final confidential questionnaire for past health visitor students 1984/5

Please tick the appropriate box and comment as fully as possible

Part I - Health visiting experience

1. Are you still practising as a health visitor?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

if no please give present occupation

----------

if yes is this the same position as when you started supervised practice?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

if no please give the reasons for changing your health visitor placement

2. During your supervised practice how were you practising health visiting?

G.P. attached  
Geographically  
G.P. aligned  
other - please specify


3. During supervised practice in which of the following situations were you based:

Health Centre  
Child Health Clinic  
G.P Surgery  
other - please specify


4. During supervised practice were you based in your practice situation alone or with other health visitors?

alone  
with others


if with others please state the number

------

To what extent did you find this interaction useful during this period?

if alone please describe how you felt about this situation.

- 

8. Please describe any other main similarities and/or differences between the health visiting you saw during your fieldwork and during your supervised practice; for example the nature of client groups, ie the socio-economic group, the ethnic group or work with the elderly.

9. To what extent were you able to carry out routine as opposed to crisis health visiting during supervised practice?

Part II - The assessment procedure

10. Did you meet your assessor on a regular basis during supervised practice?

Yes
No

if yes please state the frequency and duration of the meetings

if no would you have preferred this to have occurred?

11. Did you find these meetings;

useful  
stressful  
useless  
a combination  
(please specify)


12. Please describe briefly your understanding of the purpose of these meetings.

Did you find the meetings fulfilled this purpose?

Yes
No

Please comment on your answer

13. Did your assessor go through the assessment form informally with you during the early stages of supervised practice?

Yes
No

If yes did you find this process

stressful  
useful  
both  
neither


please comment on your answer

if no would you have found this procedure useful?

Yes
No

please comment on your answer

14. Did you find your tutor's visit to you during supervised practice useful?

Yes
No

please comment on your answer

15. What was your understanding of the purpose of this visit?

to what extent did the visit fulfil this purpose?

16. To what extent do you feel your supervised practice report was a fair assessment of your health visiting skills?

17. Did you agree with the comments made about your health visiting practice on the assessment form?

Yes
No

please comment on your answer

18. Please describe any parts of supervised practice which you found particularly stressful.

Part III - The final examination

19. Did you find the oral examination stressful?

Yes
No

please comment on your answer



20. What was your understanding of the purpose of the oral exam?
21. To what extent did you feel the oral examination fulfilled this purpose?
22. To what extent do you feel the oral examination is a useful method of assessing your health visiting skills?
23. To what extent do you feel the two health visiting studies were a useful method of assessing your health visiting skills?

24. Have you any suggestions as to how the health visiting study might be improved as a method of assessing your health visiting skills?
25. To what extent do you feel the Neighbourhood Study is a useful method of assessing your health visiting skills?
26. Have you any suggestions as to how the Neighbourhood Study might be improved as a method of assessing your health visiting skills?

27. On reflection having completed several months of health visiting are there any particular aspects of practice for which you feel the course did not adequately prepare you.

28. Are there any other ways in which you think the course might have improved your competence to practice?

Thank you very much for your help in completing this questionnaire.

Shelia Twinn